No. 14-7955 ***CAPITAL CASE***

Title: Richard E. Glossip, et al., Petitioners
v.
Kevin J. Gross, et al.

Docketed: January 14, 2015

Linked with 14A761

Lower Ct: United States Court of Appeals for the Tenth Circuit

Case Nos.: (14-6244)

Decision Date: January 12, 2015

Discretionary Court
Decision Date: December 22, 2014

Questions Presented

~~Date~~	~~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Jan 13 2015	Petition for a writ of certiorari and motion for leave to proceed in forma pauperis filed. (Response due February 13, 2015)
Jan 13 2015	Application (14A761) for stays of execution of sentences of death, submitted to Justice Sotomayor.
Jan 14 2015	Brief of respondent Kevin J. Gross, et al. in opposition filed.
Jan 14 2015	Response to application (14A761) from respondent Kevin J. Gross, et al. filed.
Jan 15 2015	Reply of petitioner Charles F. Warner, et al. filed.
Jan 15 2015	Reply of applicant Charles F. Warner, et al. filed.
Jan 15 2015	Application (14A761) referred to the Court.
Jan 15 2015	Application (14A761) denied by the Court. JUSTICE SOTOMAYOR, with whom JUSTICE GINSBURG, JUSTICE BREYER, and JUSTICE KAGAN join, dissents. (Detached Opinion)
Jan 20 2015	DISTRIBUTED for Conference of January 23, 2015.
Jan 23 2015	Motion to proceed in forma pauperis and petition for a writ of certiorari GRANTED.
Jan 26 2015	Application (14A796) of Kevin J. Gross, et al. for stays of execution of sentences of death, submitted to Justice Sotomayor.
Jan 26 2015	Response in support of application filed.
Jan 28 2015	Application (14A796) referred to the Court.
Jan 28 2015	Application (14A796) granted by the Court. Respondentsapplication for stays of execution of sentences of death presented to Justice Sotomayor and by her referred to the Court is granted and it is hereby ordered that petitionersexecutions using midazolam are stayed pending final disposition of this case.
Mar 4 2015	Consent to the filing of amicus curiae briefs, in support of either party or of neither party, received from counsel for petitioners.
Mar 6 2015	SET FOR ARGUMENT ON Wednesday, April 29, 2015
Mar 6 2015	Consent to the filing of amicus curiae briefs, in support of either party or of neither

	party, received from counsel for respondents.
Mar 9 2015	Brief of petitioners Richard E. Glossip, et al. filed.
Mar 9 2015	Joint appendix filed.
Mar 9 2015	Joint motion for leave to file volume II of the joint appendix under seal with redacted copies for the public record filed.
Mar 11 2015	Motion DISTRIBUTED for Conference of March 27, 2015.
Mar 16 2015	Brief amicus curiae of Former State Attorneys General filed.
Mar 16 2015	Brief amicus curiae of National Association of Criminal Defense Lawyers filed.
Mar 16 2015	CIRCULATED.
Mar 16 2015	Brief amicus curiae of Louis Stein Center for Law and Ethics at Fordham University School of Law filed. (Distributed).
Mar 16 2015	Brief amicus curiae of National Consensus Project The Promise of Justice Initiative filed. (Distributed)
Mar 16 2015	Brief amicus curiae of The Innocence Project filed. (Distributed)
Mar 16 2015	Brief amicus curiae of National Catholic Reporter filed. (Distributed)
Mar 16 2015	Brief amici curiae of Sixteen Professors of Pharmacology in support of neither party filed. (Distributed)
Mar 16 2015	Brief amicus curiae of The Rutherford Institute filed. (Distributed)
Mar 16 2015	Motion rescheduled.
Mar 16 2015	Brief amicus curiae of Advocates for Human Rights filed. (Distributed).
Mar 17 2015	Record requested from U.S.C.A. 10th Circuit.
Mar 24 2015	Record received from U.S.C.A. 10th Circuit is electronic.
Apr 1 2015	Motion DISTRIBUTED for Conference of April 17, 2015.
Apr 8 2015	Brief of respondents Kevin J. Gross, et al. filed. (Distributed)
Apr 14 2015	Brief amicus curiae of Criminal Justice Legal Foundation filed. (Distributed)
Apr 15 2015	Brief amicus curiae of Florida filed. (Distributed)
Apr 15 2015	Brief amici curiae of Alabama, et al. filed. (Distributed)
Apr 20 2015	Motion for leave to file volume II of the joint appendix under seal with redacted copies for the public record GRANTED.
Apr 22 2015	Reply of petitioners Richard E. Glossip, et al. filed. (Distributed)
Apr 29 2015	Argued. For petitioners: Robin C. Konrad, Phoenix, Ariz. For respondents: Patrick R. Wyrick, Solicitor General, Oklahoma City, Okla.
May 13 2015	Letter from counsel for the respondent received. (Distributed)
Jun 4 2015	Letter from counsel for amici The National Consensus Project The Promise of Justice Initiative received.
Jun 29 2015	Adjudged to be AFFIRMED. Alito, J., delivered the opinion of the Court, in which Roberts, C. J., and Scalia, Kennedy, and Thomas, JJ., joined. Scalia, J., filed a concurring opinion, in which Thomas, J., joined. Thomas, J., filed a concurring opinion, in which Scalia, J., joined. Breyer, J. filed a dissenting opinion, in which Ginsburg, J., joined. Sotomayor, J., filed a dissenting opinion, in which Ginsburg, Breyer, and Kagan, JJ., joined.
Jul 24 2015	Petition for Rehearing filed.
Aug 6 2015	DISTRIBUTED.

FILED
JAN 13 2015
OFFICE OF THE CLERK
SUPREME COURT, U.S.

No. 14-7955

IN THE SUPREME COURT OF THE UNITED STATES

Charles F. Warner; Richard E. Glossip; John M. Grant; and Benjamin R. Cole, by and through his next friend, Robert S. Jackson, Petitioners,

vs.

Kevin J. Gross, Michael W. Roach, Steve Burrage, Gene Haynes, Frazier Henke, Linda K. Neal, Earnest D. Ware, Robert C. Patton, and Anita K. Trammell, Respondents.

*****CAPITAL CASE*****
EXECUTION OF CHARLES WARNER
SCHEDULED FOR 6:00 PM (CST)
THURSDAY, JANUARY 15, 2015

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

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QUESTIONS PRESENTED
CAPITAL CASE

In *Baze v. Rees*, 553 U.S. 35 (2008), the Court held that Kentucky's three-drug execution protocol was constitutional based on the uncontested fact that "proper administration of the first drug"—which was a "fast-acting barbiturate" that created "a deep, comalike unconsciousness"—will ensure that the prisoner will not experience the known pain of suffering from the administration of the second and third drugs, pancuronium bromide and potassium chloride. *Id.* at 44.

The *Baze* plurality established a stay standard to prevent unwarranted last-minute litigation challenging lethal-injection protocols that were substantially similar to the one reviewed in *Baze*; a stay would not be granted absent a showing of a "demonstrated riak of severe pain" that was "substantial when compared to the known and available alternatives." *Id.* at 61.

In this case, Oklahoma intends to execute Petitioners using a three-drug protocol with the same second and third drugs addressed in *Baze*. However, the first drug to be administered (midazolam) is not a fast-acting barbiturate; it is a benzodiazepine that has no pain-relieving properties, and there is a well-established scientific consensus that it cannot maintain a deep, comalike unconsciousness. For these reasons, it is uncontested that midazolam is not approved by the FDA for use as general anesthesia and is never used as the sole anesthetic for painful surgical procedures.

Although Oklahoma admits that administration of the second or third drug to a conscious prisoner would cause intense and needless pain and suffering, it has selected midazolam because of availability rather than to create a more humane execution. Oklahoma's intention to use midazolam to execute the Petitioners raises the following questions, left unanswered by this Court in *Baze*:

Question 1: Is it constitutionally permissible for a state to carry out an execution using a three-drug protocol where (a) there is a well-established scientific consensus that the first drug has no pain relieving properties and cannot reliably produce deep, comalike unconsciousness, and (b) it is undisputed that there is a substantial, constitutionally unacceptable riak of pain and suffering from the administration of the second and third drugs when a prisoner is conscious.

Question 2: Does the *Baze*-plurality stay standard apply when states are not using a protocol substantially similar to the one that this Court considered in *Baze*?

Question 3: Must a prisoner establish the availability of an alternative drug formula even if the state's lethal-injection protocol, as properly administered, will violate the Eighth Amendment?

TABLE OF CONTENTS

TABLE OF CONTENTS ii
TABLE OF AUTHORITIES iv
PETITION FOR A WRIT OF CERTIORARI 1
OPINIONS BELOW 1
STATEMENT OF JURISDICTION 1
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED 1
STATEMENT OF THE CASE 2
A. Oklahoma's goal was political expediency, rather than the development of a more humane execution process, when it hastily switched to a three-drug protocol using midazolam. 3
B. Midazolam is not an acceptable substitute for sodium thiopental because it has different pharmacological properties and cannot reliably produce a deep, comalike unconsciousness. 6
C. Despite evidence both from experts and from experimental executions demonstrating that midazolam cannot reliably render a person deeply unconscious, Oklahoma intends to use midazolam in Petitioners' executions. 10
D. The district court and Tenth Circuit decisions. 12
REASONS FOR GRANTING THE WRIT 15
The practice of lethal injection has changed significantly since *Baze*, and the manner in which lower courts protect against unconstitutional executions is an issue of national importance. 16
A. The Tenth Circuit's decision cannot be reconciled with this Court's requirement that a constitutional three-drug protocol must include a first drug that reliably creates a deep, comalike unconsciousness. 21
B. The Tenth Circuit's requirement that condemned prisoners provide the government with an alternative method of execution in order to prevent them from being executed in an unconstitutional manner cannot be reconciled with this Court's "evolving standards of decency" jurisprudence. 21
CONCLUSION 24

APPENDIX INDEX

Tenth Circuit Opinion, Jan. 12, 2015 ..... App. A

District Court Order, 2014, ECF No. 173 ..... App. B

Transcript of Court's Ruling, Dec. 22, 2014 ..... App. C

Expert Report of David A. Lubarsky, M.D., MBA, admitted as Plaintiffs' exhibit 80 during hearing on preliminary injunction ..... App. D

Expert Report of Larry D. Sasich, Pharm.D., MPH, FASHP, admitted as Plaintiffs' exhibit 77 during hearing on preliminary injunction ..... App. E

Declaration of David A. Lubarsky, M.D., MBA, attached as Ex. 4 to Emergency Mot. for Stays of Executions Pending Appeal, filed Jan. 8, 2015 ..... App. F

Larry D. Sasich, Pharm.D., MPH, FASHP, Review of State's Expert Report, attached as Ex. 5 to Emergency Mot. for Stays of Executions Pending Appeal, filed Jan. 8, 2015 ..... App. G

Expert Report of R. Lee Evans, Pharm.D., FASHP, FCCP, BCPP, admitted as Defendants' exhibit 34 during hearing on preliminary injunction ..... App. H

TABLE OF AUTHORITIES

FEDERAL CASES

Baze v. Rees, 553 U.S. 35 (2008) ..... *passim*

Brewer v. Landrigan, 131 S. Ct. 445 (2010) 18

Chavez v. Florida SP Warden, 742 F.3d 1267 (11th Cir. 2014) 20

Farmer v. Brennan, 511 U.S. 825 (1994) 22

McCullen v. Coakley, 134 S. Ct. 2518 (2014) 22

Pavatt v. Jones, 627 F.3d 1336 (10th Cir. 2010) 23

DOCKETED CASES

Frazier v. Thomas, Case No. 2:13-cv-00781-WKW (M.D. Ala.) 19

In re: Ohio Execution Protocol Litigation, 2:11-cv-1016-GLF-MRA (S.D. Ohio) 5

CONSTITUTIONAL PROVISIONS

U.S. Constitution amend. VIII 1

FEDERAL STATUTES

28 U.S.C. § 1254(1) 1

42 U.S.C. § 1983 1-2

PETITION FOR A WRIT OF CERTIORARI

Charles F. Warner, Richard E. Gloeaip, John M. Grant, and Benjamin R. Cole, by and through his next friend Robert S. Jackson, respectfully petition this Court for a writ of certiorari to review the judgment of the Tenth Circuit Court of Appeals rejecting their allegations of Eighth Amendment violations.

OPINIONS BELOW

The published opinion of the United States Court of Appeals for the Tenth Circuit denying relief is reported at __ F.3d __, 2015 WL 137627, and is attached *infra*, App. A. The order of the United States District Court denying relief is attached *infra*, App. B, and the transcript of the district court's ruling is attached *infra*, App. C.

STATEMENT OF JURISDICTION

The court of appeals issued its decision affirming the district court's denial of a preliminary injunction on January 12, 2015. This petition is timely. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Eighth Amendment to the United States Constitution: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

Title 42, section 1983, of the United States Code: "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or

Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . ."

STATEMENT OF THE CASE

This Petition asks this Court to revisit its decision in *Baze v. Rees*, 553 U.S. 35 (2008), because the lethal-injection landscape has changed significantly in the last seven years. The three-drug formula using the barbiturate sodium thiopental as the first drug—a formula that was created by an Oklahoma medical examiner in the late 1970s[1] and reviewed by this Court in *Baze*—is no longer being used to carry out executions in the United States. Instead, states now experiment with various drug formulations that have resulted in multiple malfunctioning executions—indeed, spectacles—over the past year. The bungled executions are unsurprising, because they arise from the use of midazolam, a drug that is *pharmacologically unable* to conform to the constitutional requirements in *Baze*. Thus, these new experiments have resulted in the types of unconstitutional executions that *Baze* was designed to prevent.

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[1] *See Baze*, 553 U.S. at 117 (Ginsburg, J., dissenting).

Oklahoma intends to execute Petitioners by lethal injection using a three-drug protocol substantially different from the one this Court reviewed in *Baze*.[1] The Oklahoma protocol will begin with the administration of an intravenous injection of 500 milligrams of midazolam, followed by the administration of 100 milligrams of rocuronium bromide (a paralytic), and then 240 milliequivalents of potassium chloride (a heart-stopping agent). (Dist. Ct. ECF No. 119-1; Supp. Vol. X at 333 (Att.D-OP-040301 Chart D.) It is uncontested that administering a paralytic (such as pancuronium, vecuronium, or rocuronium bromide), and/or potassium chloride to a conscious person would cause intense and needless pain and suffering. (Dist. Ct. ECF Nos. 75, 96, ¶50.) Because of the pharmacological properties of midazolam, Oklahoma cannot constitutionally carry out Petitioners' executions.

A. Oklahoma's goal was political expediency, rather than the development of a more humane execution process, when it hastily switched to a three-drug protocol using midazolam.

Until March 2014, Oklahoma used pentobarbital, a barbiturate similar to sodium thiopental, as the first drug in its three-drug execution protocol. (Tr. 12/17/2014 at 90:22-91:3.) In mid-March, with April execution dates pending for Clayton Lockett and Petitioner Charles Warner, the Oklahoma Attorney General advised the Oklahoma Department of Corrections to use midazolam, a

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[1] The execution of Charles Warner is set for January 15, 2015; the execution of Richard Glossip is set for January 29, 2015; the execution of John Grant is set for February 19, 2015; and the execution of Benjamin Cole is set for March 5, 2015. (App. C at 9:5-10.)

benzodiazepine, as the first drug, retaining the paralytic and potassium chloride as the second and third drugs in the formula. (Tr. 12/18/2014 at 469:3-6.) The Attorney General did not choose midazolam because it would lead to a more humane method of executing the condemned; the Attorney General chose midazolam out of convenience and political expediency to ensure that then-scheduled executions would go forward. (Tr. 12/18/2014 at 289:22-24; Tr. 12/18/2014 at 290:2-6.)

Based in part on the Department of Corrections' General Counsel's research of midazolam on the internet, including "Wiki leaks or whatever it is" (Supp. Vol. II at 211:19-22), Oklahoma used midazolam for the first time in its execution of Clayton Lockett. Mr. Lockett was administered 100 milligrams of midazolam, and seven minutes later, he was declared unconscious by the attending physician-executioner. (App. C at 13:5-22; Tr. 12/17/2014 at 214:8-215:10.) Mr. Lockett was then administered the second drug, the paralytic vecuronium bromide, and most of the third drug, potassium chloride. (App. C at 13:22-24; Tr. 12/17/2014 at 170:2-4.) After being declared unconscious, he began to speak, buck, raise his head, and writhe against the gurney (App. C at 13; Tr. 12/17/2014 at 19:6-16, 181:17-25, 193:1-194:3, 205:19-21; Tr. 12/18/2014 at 219:19-220:12; Tr. 12/19/2014 at 494:8-25).

Subsequently, as the district court found, post-execution analysis confirmed that Mr. Lockett's blood contained enough midazolam to render the average person unconscious. (App. C at 18:13-15.) Thus, according to accounts from the physician-

executioner and the toxicology analysis, Mr. Lockett had become unconscious from the midazolam. Despite Oklahoma's awareness of both the fact that midazolam rendered Mr. Lockett unconscious and the fact that Mr. Lockett regained consciousness *after* he had been declared unconscious, the state did not abandon its use of midazolam.[3] Instead, the Department Director maintained the use of midazolam in a three-drug protocol "because a court in Florida found it constitutional." (Tr. 12/18/2014 at 508:1-7.) The Director relied upon the Attorney General's office, rather than his own consultation with medical professionals, in determining whether "midazolam is a reliable drug that would produce a level of unconsciousness" sufficient to prevent prisoners from experiencing pain and suffering from the second and third drugs. (Tr. 12/18/2014 at 509:10-510:5.) In the face of subsequent evidence from an anesthesiologist that midazolam has no analgesic properties and that increasing its dosage does not increase its effect, the Director continues to hold steadfast to his reliance upon the advice of the Attorney General's office that midazolam is an appropriate drug for executions. (Tr. 12/18/2014 at 509:10-510:17.)

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[3] Ohio, on the other hand, abandoned its use of midazolam after its problematic execution of Dennis McGuire last year. *See* Alan Johnson, *Ohio revises death penalty protocol, will delay executions*, The Columbus Dispatch, Jan. 9, 2015, *available at* http://www.dispatch.com/content/stories/local/2015/01/08/death-penalty-protocol.html (last visited Jan. 11, 2015) (reporting that Ohio is dropping use of midazolam and hydromorphone after it "caused problems in the last execution"); *see also In re: Ohio Execution Protocol Litigation*, 2:11-cv-1016-GLF-MRA, Order (S.D. Ohio filed Jan. 9, 2015), ECF No. 509 (vacating scheduling order in light of new protocol).

B. Midazolam is not an acceptable substitute for sodium thiopental because it has different pharmacological properties and cannot reliably produce a deep, comalike unconsciousness.

The Court's holding in *Baze* is premised on three key facts. First, it was uncontested that administering either a paralytic (such as pancuronium, vecuronium, or rocuronium bromide) or potassium chloride (or both) to a conscious person would be unconstitutional. *Baze*, 553 U.S. at 53. Second, sodium thiopental, the first drug at issue in *Baze*, was a "fast-acting barbiturate," a drug used for general anesthesia and designed to produce "a deep, comalike unconsciousness when given in the amounts used for lethal injection." *Id.* at 44. Third, because sodium thiopental acts as an anesthetic at the levels administered, "[t]he proper administration of the first drug *ensures* that the prisoner does not experience any pain" from the administration of the second and third drugs. *Id.* at 44 (emphasis added).

The first finding from *Baze* is undisputed here, and the second finding is equally uncontested; midazolam is *not* in the same class of drugs as sodium thiopental. It is *not* a barbiturate, but a benzodiazepine—an entirely different class of drug, with different pharmacological properties and different intended uses. (App. C at 41:4; Tr. 12/17/2014 at 109:8-10.)

The key point of contention in this case is the third *Baze* finding: whether the "proper administration" of midazolam will "ensure" that Petitioners will not experience the pain caused from the second and third drugs. Unlike the petitioners

in *Baze*, Petitioners here have not—and in light of scientific data cannot—concede that the use of 500 milligrams of midazolam, even if properly administered can reliably produce a deep, comalike unconsciousness, such that a prisoner will not feel pain and suffering from the second and third drugs.

There are several uncontested facts that make midazolam an unreliable drug to assure that a deep, comalike unconsciousness is achieved:

1. Midazolam is not an analgesic, meaning it has no pain-relieving properties. (App. C at 41:11-12; Tr. 12/17/2014 at 107:18-108:3; Tr. 12/18/2014 at 342:19-21; Tr. 12/19/2014 at 599:18-19; Tr. 12/19/2014 at 661:8-9.) Thus, the administration of midazolam alone will not prevent one from feeling pain from noxious stimuli. (Tr. 12/17/2014 at 143:21-24.)

2. Midazolam has not been approved by the Food & Drug Administration (FDA) to be used as the sole drug to maintain general anesthesia in surgical proceedings. (Tr. 12/19/2014 at 653:12-14; *see also* App. C at 41:6-10; Tr. 12/17/2014 at 107:11-12.) Respondents' own witness, R. Lee Evans, Pharm.D., testified that he would not condone the use of midazolam for general anesthesia in a painful procedure. (Tr. 12/19/2014 at 674:12-17.) And two practicing physicians who administer midazolam on a daily basis in the emergency room and operating room testified that midazolam would never be used as the sole anesthetic during surgery. (Tr. 12/17/2014 at 135:17-18; Tr. 12/19/2014 at 599:14-19.)

3. Respondents' own expert witness testified that there are no studies supporting his contention that 500 milligrams of midazolam will render a prisoner "unconscious and insensate to the noxious stimuli presented by the second and third drug in the lethal-injection protocol in Oklahoma." (Tr. 12/19/2014 at 653:15-22.) There are, however, clinical trials that were conducted when midazolam was being introduced and the manufacturer obtained FDA approval. (Tr. 12/18/2014 at 345:10-14.) These trials showed that patients who were "given midazolam in doses sufficient to produce unconsciousness d[id] not tolerate the noxious stimuli of surgery." (Tr. 12/17/2014 at 143:21-24.) Indeed, the midazolam product label does not list anesthesia as a use for midazolam—meaning that the FDA did not approve its use "as a single agent to try and perform any kind of surgical procedure." (Tr. 12/18/2014 at 345:20-25.) Thus, while there is no scientific evidence supporting its use as intended by Oklahoma, there are actual scientific and medical data demonstrating that midazolam cannot reliably render a person unconscious and insensate for purposes of undergoing surgery.

4. Benzodiazepines, the family of drugs to which midazolam belongs, have a "ceiling" effect, meaning that there is a certain point after which giving more of the drug does not result in added effect. (*See* Tr. 12/17/2014 at 109:5-6; Tr. 12/18/2014 at 343:10-17; Tr. 12/18/2014 at 358:19-23.) Even Respondents' witness acknowledged a ceiling effect. (Tr. 12/19/2014 at 663:8-10) (When asked, "[i]s it your opinion that there is no ceiling effect with midazolam," Evans responded,

"That's not what I said."). The ceiling effect means that a large dose of midazolam—even well beyond the typical therapeutic dose—*will not and cannot* reliably produce the intended effect of surgical anesthesia. The ceiling-effect phenomenon and its relevance here was established through expert testimony supported by scholarly articles and related research (Tr. 12/17/2014 at 113:2-6), and evidenced by Arizona's two-hour-long execution of Joseph Wood. Mr. Wood received 750 milligrams of midazolam, but even this massive dose did "not cause cessation of breathing or prevent movement, both of which are present during extremely deep levels of anesthesia." (Supp. Vol. XXIV at 6, ¶19; *see also* Tr. 12/17/2014 at 151:4-9.)

5. Midazolam can have an adverse effect, known as a paradoxical reaction. (Tr. 12/18/2014 at 347:12-25; Tr. 12/19/2014 at 669:3-5.) Some individuals who receive midazolam will not be sedated by midazolam; instead, they will experience "agitation, combativeness, and anxiety as a result of the administration of the drug." (Tr. 12/17/2014 at 114:14-15.) If a person experiences a paradoxical reaction to midazolam, the administration of additional midazolam will simply increase the paradoxical reaction rather than alleviate it. (Tr. 12/17/2014 at 115:17-21.) The fact that a paradoxical reaction can occur is an additional and separate risk presented by the use of midazolam. It is known that the risk is greater in individuals with histories of substance abuse, aggression, or psychiatric disorders, which Petitioners (like most death-row prisoners) have. (Tr. 12/17/2014 at 116:2-5; Tr. 12/18/2014 at 350:9-24; Supp. Vol. XXIV at 80-82; Supp. Vol. XXIV at 83-113;

Supp. Vol. XXIV at 114-121; Supp. Vol. XXIV at 122.) Such an additional risk highlights both the pharmacological inappropriateness of using the drug for this purpose, and the deliberate indifference exhibited by state officials who ignore not only the certainty of the lack of anesthesia, but the added risk of harm from a paradoxical reaction.

C. Despite evidence both from experts and from experimental executions demonstrating that midazolam cannot reliably render a person deeply unconscious, Oklahoma intends to use midazolam in Petitioners' executions.

Even though the Department Director is aware that midazolam has no analgesic properties and has a ceiling effect, he is nevertheless "confident" that midazolam, as it is intended to be used in Petitioners' executions, will produce a level of unconsciousness sufficient to prevent pain and suffering from the second and third drugs. (Tr. 12/18/2014 at 509:5-17.) The Director did not base his determination on his own knowledge—much less on evidence presented—but rather on what he learned from being "briefed by the Attorney General's office." (Tr. 12/18/2914 at 510:16-17.) The Director has decided to use midazolam despite evidence not only from experts, but also from Oklahoma's own execution of Clayton Lockett and Arizona's execution of Joseph Wood, all of which show that midazolam cannot reliably produce a deep, comalike unconsciousness.

Ordinarily, a three-drug protocol would obscure the evidence about how midazolam actually performs, because the paralytic hides the drug's ineffectiveness

from witnesses' observation. But Joseph Wood's execution did not include a paralytic. And the bungled execution of Mr. Lockett, in which the IV failure limited the paralytic's effect, revealed how midazolam performs—or rather, does not perform—in an execution.

The Director is familiar with Arizona's execution of Joseph Wood, which occurred several months after the execution of Mr. Lockett. (Tr. 12/18/2014 at 511:5-8.) The State of Arizona used 750 milligrams of midazolam (coupled with 750 milligrams of hydromorphone) in its execution of Mr. Wood, yet it took him nearly two hours to stop breathing, thus demonstrating midazolam's ceiling effect. (Tr. 12/17/2014 at 511:4-9; *see also* Supp. Vol. XXIV at 6, ¶19.)

Likewise, in the execution of Mr. Lockett, the failure of the paralytic to take immediate effect, due to IV failure, provided critical evidence about why midazolam is pharmacologically and constitutionally an inappropriate drug for executions.[4] If a prisoner is administered 100 milligrams of a paralytic, he "would be chemically paralyzed" or "'locked in,' where [he's] fully awake, [he] can't move, [he] can't blink, [he] can't move on [his] own." (Tr. 12/19/2014 at 600:1-4; *see also* Tr. 12/17/2014 at 126:10-17.)[5] But Mr. Lockett did not become paralyzed, because the drug infiltrated

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[4] Midazolam, unlike vecuronium bromide, has a rapid absorption rate whether injected through the vein or intramuscularly. (Supp. Vol. XXIV at 3, ¶10; Tr. 12/14/2014 at 116:6-25.) Vecuronium bromide, however, would have been more slowly absorbed. (Tr. 12/17/2014 at 119:23-120:14, 121:9-11.)

[5] "The only purpose of the administration of the vecuronium bromide is to make the execution more aesthetically pleasing to observers in that it reduces the

his tissue. (Tr. 12/17/2014 at 119:12-119:25.) Instead, he awoke after he had been determined to be unconscious, and he experienced the slow effects of the paralytic. (Tr. 12/17/2014 at 120:3-9.) What happened to Mr. Lockett confirms the existing medical data that midazolam is incapable of reliably maintaining a deep, comalike level of unconsciousness.

In the face of this evidence, Oklahoma still intends to carry out Petitioners' executions using a three-drug protocol, with midazolam as the first drug.

D. The district court and Tenth Circuit decisions.

After the bungled execution of Clayton Lockett on April 29, 2014,[6] Petitioners and others filed a lawsuit challenging the constitutionality of the manner and means by which Oklahoma intends to execute them. (Dist. Ct. ECF Nos. 1, 75.) Petitioners subsequently filed a motion for preliminary injunction, alleging that because of midazolam's pharmacological properties and the known data regarding its lack of effectiveness, its use as the first drug in a three-drug protocol is unconstitutional. (Dist. Ct. ECF No 92.)

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ability of the individual being executed to move or show any pain associated with the execution process." (Supp. Vol. XXIV at 5, ¶13.)

[6] The district court found that the execution of Mr. Lockett was "ineptly performed" (App. C at 7:7-9.), and the medical experts who testified described it as a "disorganized mess" (Tr. 12/17/2014 at 83:21) and a "horrendous error in judgment" (Tr. 12/19/2014 at 561:16-17). The warden overseeing the execution described it as a "bloody mess" (Supp. Vol. II at 88), and the paramedic executioner described the whole process as "a cluster" (Supp. Vol. VI at 400).

The district court held a preliminary-injunction hearing, then denied relief in an oral ruling from the bench. (*See* App. C.) The court found that although using midazolam *does* increase the risk that a prisoner would feel pain during the administration of the second and third drugs, "nobody knows" how much greater that risk is. (App. C at 45:2-6.) Despite the uncontested evidence that midazolam has no analgesic properties and is not approved for use as an anesthetic in surgery, despite the uncontested evidence that without proper anesthesia, a prisoner will suffer an unconstitutional execution when administered the paralytic and the potassium chloride, and despite knowing that there were risks in using midazolam, the district court determined that 500 milligrams of midazolam "would make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs." (App. C at 42:5-8.) Accordingly, the court found that Petitioners had not demonstrated a risk that the use of midazolam is "'sure or very likely to cause serious illness and needless suffering,' amounting to an 'objectively intolerable risk of harm.'" (App. C at 60:19-25–61:1) (citing *Baze*, 553 U.S. at 50).

In reaching its conclusion regarding the degree of risk at issue here, the district court also required Petitioners to provide an alternative method of execution. The court asserted: "It is extremely unlikely that the Supreme Court would establish a constitutional doctrine that would enable a condemned inmate to block his execution on Eighth Amendment grounds with no consideration by the

Court of alternatives which by way of comparison demonstrate the constitutional unacceptability of the risk complained of by the prisoner." (App. C at 57:10-16.) The court applied the *Baze* stay standard, which states:

> A stay of execution may not be granted on grounds such as those asserted here unless the condemned prisoner establishes that the state's lethal injection protocol creates a demonstrated risk of severe pain. He must show that the risk is substantial when compared to the known and available alternatives. A state with a lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard.

(App. C at 56:7-14) (quoting *Baze*, 553 U.S. at 61). The court, therefore, required Petitioners to propose a "known and available" alternative to the use of midazolam—thus establishing a standard that requires condemned prisoners to experience an unconstitutional execution unless they are able to conduct research, provide a source of drug, and then offer a constitutional protocol. In so doing, the court rejected the argument that *Baze* was distinguishable because Petitioners here have *never* conceded that a three-drug protocol using midazolam, even if "properly administered," will be humane. (App. C at 56:16-19.)

The Tenth Circuit affirmed the denial of preliminary injunctive relief, adopting wholesale the district court's opinion. Like the district court, the Tenth Circuit ignored the uncontested facts about midazolam's known pharmacological properties. As a result, it did not address the core difference between this case and *Baze*, rooted in the difference between midazolam and sodium thiopental. (App. A at 22-27.)

The Tenth Circuit also applied the *Baze* stay standard, assuming (as the district court did) that Oklahoma's protocol using midazolam is "substantially similar" to the one at issue in *Baze*, and that Petitioners must show a known and available alternative. (App. A at 19.) Finally, rejecting Petitioners' argument that *Baze* was specific to the challenges to the established and "widely tolerated" drug protocol submitted to this Court for review in that case, the Tenth Circuit held that *Baze* applies to "all challenges to 'a State's chosen procedure for carrying out a sentence of death.'" (App. A at 21.)

REASONS FOR GRANTING THE WRIT

As prisoners have raised legal challenges to novel execution methods, the lower courts have been forced to react to ever-changing lethal injections when they apply *Baze*. Consequently, lower courts have empowered the states use *Baze* to insulate their protocols from any meaningful review—leaving the Eighth Amendment no work to do in protecting constitutional rights. First, the courts have treated *Baze* as a shield, protecting state execution protocols against any challenge. This has enabled the states to engage in unconstrained experimentation, heedless of empirical scientific evidence, and without any need to show that the experimentation is in the service of creating more humane executions. Second, the courts have simultaneously treated *Baze* as a sword, knocking down challenges to a protocol's unconstitutionality whenever the state claims it cannot obtain any other drugs, without any inquiry into the constitutionality of the chosen formula.

By granting review in this case, the Court will provide urgently needed guidance, both to prisoners seeking to challenge the states' new execution methods, and to the courts charged with reviewing such claims. Particularly because challenges to execution practices are often, and necessarily, litigated in the shadow of a looming execution date, this Court's guidance will minimize the last-minute, truncated litigation that necessarily results in inadequate review of constitutional claims.

The practice of lethal injection has changed significantly since *Baze*, and the manner in which lower courts protect against unconstitutional executions is an issue of national importance.

In 2008, when *Baze* was decided, "lethal injection" in executions meant a three-drug formula using sodium thiopental—a drug that acted as a general anesthetic at the doses used in lethal injection—as the first drug, followed by pancuronium bromide, and then potassium chloride. Thirty-six states and the federal government used lethal injection as the preferred method of execution. *Baze*, 553 U.S. at 52. The Court found it difficult to find this "widely tolerated" practice to be "objectively intolerable." *Baze*, 553 U.S. at 53.

Seven years later, the term "lethal injection" no longer has the same meaning. Thirty-two states have the death penalty, along with the federal government and the United States military.[7] But while those jurisdictions use

[7] *See* Death Penalty Information Center, States With and Without the Death Penalty, *at* http://www.deathpenaltyinfo.org/states-and-without-death-penalty (last

lethal injection as the primary method of execution, the drugs, drug combinations, and drug doses vary widely from state to state. Additionally, execution protocols in some states, like Oklahoma, provide a choice of multiple drug combinations.[8] There is no longer a single, or even a predominant, drug formula, as there was when the Court considered the constitutionality of lethal injection in *Baze*.

With the ever-changing drug protocols,[9] the states have turned the stay standard established in *Baze* into both shield and sword, designed to protect their

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visited Jan. 9, 2015).

[8] *See* Death Penalty Information Center, State by State Lethal Injection, *at* http://www.deathpenaltyinfo.org/state-lethal-injection (last visited Jan. 12, 2015).

[9] In 2013 and 2014, at least twelve states made changes to their execution protocols, with some states making changes multiple times. *See Alabama Changes Execution Drug Combination*, THE ASSOCIATED PRESS, Sept. 12, 2014 at http://wiat.com/2014/09/12/alabama-changes-execution-drug-combination/ (last visited on Jan. 13, 2015); Arizona Department of Corrections, Department Order 710, Revised March 26, 2014; Arkansas Department of Corrections, Lethal Injection Procedure Attachment C, revised April 11, 2013; Florida Department of Corrections, Execution by Lethal Injection Procedures, effective September 9, 2013; *Kentucky Dropping 2-drug executions*, The Associated Press, November 14, 2014 at http://www.wlwt.com/news/kentucky-drops-2drug-executions-reworking-method/29716428 (last visited Jan. 13, 2015); State of Louisiana Department of Public Safety and Corrections, Department Regulation No. C-03-001, effective March 12, 2014; Missouri Department of Corrections, Preparation and Administration of Chemicals for Lethal Injection, revised October 18, 2013; Montana Department of Corrections, Montana State Prison Execution Technical Manual, effective January 16, 2013; North Carolina Department of Corrections, Execution Procedure Manual, effective October 24, 2013; State of Ohio Department of Rehabilitation and Corrections, 01-COM-22, effective October 10, 2013; State of Ohio Department of Rehabilitation and Corrections, 01-COM-22, effective April 28, 2014; Oklahoma Department of Corrections, OSP-040301-01, effective March 21, 2014; Oklahoma Department of Corrections, OSP-040301-01, effective April 28, 2014; Lucas L. Johnson II, *Tennessee Revises Protocol for Executions*, The Associated Press, Sept. 30, 2013 at http://www.memphisdailynews.com/

protocols from genuine constitutional scrutiny. They do so by continuously selecting new drug protocols while, at the same time, seeking to carry out executions, thus forcing prisoners to develop and present their claims under highly truncated schedules that provide neither adequate time, nor adequate discovery to develop a record. The states then claim that the prisoner is not entitled to a stay because *Baze* requires petitioners to establish both a "demonstrated showing" of a substantial risk of severe pain and a "known and available" alternative formula.

But this cannot be what the Court intended when it established this standard.[10] Rather, such a stay standard should be interpreted as providing states and courts a shield against *frivolous* lawsuits brought at the last minute to challenge long-established protocols that were "substantially similar" to that reviewed in *Baze*. It should not be construed, as the states and the courts have thus far done, to allow states to experiment with new drug protocols, all the while cutting off meaningful constitutional review. States should not be permitted to evade careful court review of their execution protocols by repeatedly mooting condemned prisoners' claims by executing them under a standard that—by circumstances of the states' own making—prevents review.

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news/2013/sep/30/tennessee-revises-protocol-for-executions/ (last visited on Jan.13, 2015).

[10] This Court's order, which applied *Baze* when it reversed a stay of execution, was four years ago and does not address the issue here. *Brewer v. Landrigan*, 131 S. Ct. 445 (2010) (mem) (reversing stay where there was "no evidence in the record to suggest that the drug obtained from a foreign source is unsafe" and where the district court "was left to speculate as to the risk of harm").

In this case, as in other states, Oklahoma has turned to midazolam, not because it makes executions more humane, but because it is available on the market. Oklahoma, like other states, seeks to apply *Baze*'s stay standard in a manner that will allow unconstitutional executions to proceed in Oklahoma and elsewhere.

Since 2013, eleven executions have been carried out using a three-drug formula with midazolam as the first drug—all but the Lockett execution have taken place in Florida.[11] Ohio and Arizona have each carried out one execution using a combination of midazolam and hydromorphone.[12] While most of the executions in 2013 and 2014 relied on manufactured or compounded pentobarbital either in a one-drug or three-drug protocol,[13] states have begun to turn to midazolam as the drug of choice.[14] And the states are doing so *not* because midazolam presents a safer or

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[11] *See* Death Penalty Information Center, Execution List 2014, *at* http://www.deathpenaltyinfo.org/execution-list-2014 (last visited Jan. 14, 2015); Death Penalty Information Center, Execution List 2013, *at* http://www.deathpenaltyinfo.org/execution-list-2013 (last visited Jan. 14, 2015).

[12] *See id.*; *see also* Lawrence Hummer, *I Witnessed Ohio's Execution of Dennis McGuire. What I Saw Was Inhumane*, GUARDIAN, Jan. 22, 2014, *at* http://www.theguardian.com/commentisfree/2014/jan/22/ohio-mcguire-execution-untested-lethal-injection-inhumane (last visited Jan. 13, 2015); Michael Kiefer, *Arizona inmate injected 15 times, records show*, ARIZONA REPUBLIC, Aug. 1, 2014, *at* http://www.azcentral.com/story/news/local/arizona/2014/08/01/arizona-botched-execution-report-injections/13492511/ (last visited Jan. 13, 2015).

[13] *See id.*

[14] *See, e.g.*, *Frazier v. Thomas*, Case No. 2:13-cv-00781-WKW, Mem. Op. and Order at 2-3 (M.D. Ala. filed Jan. 5, 2015), ECF No. 19 (noting that Alabama announced it will use midazolam in three-drug protocol); Letter to Arizona Governor Janice K. Brewer from Arizona Dep't of Corr. Director Charles L. Ryan,

more humane method of execution, but simply because they can readily obtain it, and because it was deemed constitutional in Florida based on preliminary-injunction review applying the *Baze* stay standard.

States seek to use new experimental protocols, claiming that these protocols are *Baze*-compliant, even though the drug protocols are substantially different from that at issue in *Baze*. There is no longer a consensus among the states regarding appropriate lethal-injection formulas.[15] Without guidance from this Court, Oklahoma and other states have moved and will continue to move to new, experimental drug combinations that are materially different from and much riskier than the one considered in *Baze*, and will do so in spite of the empirical data demonstrating the increased risk of serious harm.[16]

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dated Dec. 22, 2015, *at available* https://corrections.az.gov/sites/default/files/documents/PDFs/letter_to_governor_brewer.pdf (last visited Jan. 11, 2015) (noting that Arizona intends to use midazolam in three-drug protocol); *Chavez v. Florida SP Warden*, 742 F.3d 1267, 1269 (11th Cir. 2014) (stating that Florida adopted a three-drug protocol using midazolam); Rachel Weiner, *Virginia details protocol for controversial execution drug*, WASHINGTON POST, Apr. 30, 2014 *available at* http://www.washingtonpost.com/news/post-nation/wp/2014/04/30/virginia-details-protocol-for-controversial-execution-drug/ (last visited Jan. 13, 2015) (reporting that Virginia will use midazolam in three-drug protocol).

[15] There is, however, consensus of scientific data that midazolam cannot reliably create a deep, comalike anesthesia, as explained *supra* at 12-14.

[16] *See* App. A at 14; *Chavez*, 742 F.3d at 1272 (applying *Baze* stay requirements to protocol using midazolam).

A. The Tenth Circuit's decision cannot be reconciled with this Court's requirement that a constitutional three-drug protocol must include a first drug that reliably creates a deep, comalike unconsciousness.

In *Baze*, the risks associated with the use of sodium thiopental were those created by inadequate dosing and maladministration. With midazolam, there is no dose that can reliably maintain unconsciousness at the surgical plane of anesthesia, and increasing the dose cannot overcome the risk. Simply put, even the *proper* administration of midazolam results in an inhumane execution.

Despite the record evidence and uncontested facts establishing the material differences between midazolam and sodium thiopental, the Tenth Circuit treated the Oklahoma protocol as indistinguishable from the one at issue in *Baze*, and therefore held that Petitioners could not satisfy *Baze*'s stay standard. Under the Tenth Circuit's approach, any lethal-injection formula will be treated as "substantially identical" to that in *Baze*, and will avoid searching review in the federal courts. This cannot be the constitutional standard this Court intended to adopt in *Baze*.

B. The Tenth Circuit's requirement that condemned prisoners provide the government with an alternative method of execution in order to prevent them from being executed in an unconstitutional manner cannot be reconciled with this Court's "evolving standards of decency" jurisprudence.

The Constitution does not require those who challenge the constitutionality of governmental actions to simultaneously offer remedies to the government. A

requirement that plaintiffs delineate a remedy alongside their constitutional challenges would lead to an absurd result: If a petitioner were unable to imagine a constitutional remedy to unconstitutional activity—beyond requiring the state to stop engaging in the unconstitutional conduct—then the government would be allowed to continue to act in an unconstitutional fashion.[17] That cannot be the case.

The fallacy of such a requirement can be seen in, for example, in a First Amendment challenge to "buffer zones" around abortion clinics and an Eighth Amendment challenge to prison conditions. *See McCullen v. Coakley*, 134 S.Ct. 2518, 2530 (2014) (providing no requirement that plaintiffs "imagine[] alternatives" to the challenged buffer zone, and ruling in the absence of such alternatives that the existing zone was unconstitutional); *Farmer v. Brennan*, 511 U.S. 825, 845-46 (1994) (noting that transsexual prisoner who sued prison for deliberate indifference need only plead "a contemporary violation of a nature likely to continue"; no requirement of an alternative remedy). In neither of these cases did the Court require the petitioners to offer constitutional alternatives or remedies that would reduce the risk of constitutional violations.

And yet, that is precisely what the Tenth Circuit held below. That court read *Baze* to require prisoners to identify a "known and available" alternative drug formula in order to obtain a stay of execution or to prevail on the merits of their

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[17] Additionally, from a practical standpoint, those who challenge governmental actions are often not qualified to make affirmative decisions about actions in the governmental sphere.

claims. The Tenth Circuit was relying on its own precedent that requires a prisoner to propose an alternative. (App. A at 20) (citing *Pavatt v. Jones*, 627 F.3d 1336 (10th Cir. 2010)). *Pavatt*, however, was challenging a method of execution similar to that presented in *Baze*, in which the state was using a barbiturate as the first drug in a three-drug protocol. *Pavatt*, 627 F.3d at 1337. Nevertheless, according to the Tenth Circuit, this rule applies—and will apply "absent superseding . Supreme Court decisions" (App. A at 20)—even if the state's chosen method is unconstitutional. Again, this cannot be what the Court intended in *Baze*, yet without this Court's intervention, lower courts will continue to impose this requirement upon plaintiffs.

Moreover, a standard that evaluates the constitutionality of a given drug *not* on empirical scientific data, but rather on a prisoner's inability to act as an informed advisor to the government, or on the asserted market unavailability of sodium thiopental, would mean that the constitutionality of midazolam on any given day is determined by the prisoner's ability to act as an advisor, or by the business decisions of private corporations to make and market a particular drug. If that were the standard, then the use of midazolam could be constitutional this week, unconstitutional next week if sodium thiopental becomes "available," and then constitutional again the week after that. The Eighth Amendment standard is not a fluctuating one, and the Tenth Circuit's interpretation of "alternative" cannot be the law. Especially when it comes to the constitutional violation at issue—a

lingering and agonizing death—a private manufacturer's decision to stop distributing a drug cannot inoculate a ghastly practice from constitutional scrutiny.

CONCLUSION

For the reasons stated, this Court should grant the Petition for Writ of Certiorari.

Respectfully submitted: January 13, 2015.

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No. 14-7955

IN THE SUPREME COURT OF THE UNITED STATES

CHARLES F. WARNER; RICHARD E. GLOSSIP; JOHN M. GRANT; and BENJAMIN R. COLE, by and through his next friend, Robert S. Jackson,

Petitioners,

vs.

KEVIN J. GROSS; MICHAEL W. ROACH; STEVE BURRAGE; GENE HAYNES; FRAZIER HENKE; LINDA K. NEAL; EARNEST D. WARE; ROBERT C. PATTON and ANITA K. TRAMMELL,

Respondents.

CAPITAL CASE
EXECUTION OF CHARLES WARNER
SCHEDULED FOR 6:00 PM (CST)
THURSDAY, JANUARY 15, 2015

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

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QUESTIONS PRESENTED

Question 1: Should this Court grant certiorari to review the Tenth Circuit's proper application of this Court's holding in *Baze*, as well as the Tenth Circuit's decision to affirm the district court finding that the first drug created a virtual certainty that the offender would rendered unconscious and able to resist the noxious stimuli of the second and third drugs?

Question 2: Should this Court grant certiorari to determine that the *Baze* standard applies when states are not using a protocol that implements the use of sodium thiopental as the first drug?

Question 3: Should this Court grant certiorari to re-emphasize that a prisoner must establish the availability of an alternative drug formula when challenging a state's method of execution?

TABLE OF CONTENTS

QUESTIONS PRESENTED ii

TABLE OF CONTENTS iii

TABLE OF AUTHORITES .....

BRIEF IN OPPOSITION 1

OPINIONS BELOW 1

JURISDICTION 2

PROCEDURAL HISTORY 2

STATEMENT OF THE CASE 3

A. OKLAHOMA'S EXECUTION PROTOCOL 4

B. OKLAHOMA'S CHOICE OF MIDAZOLAM 4

C. THE DISTRICT COURT DECISION 5

D. THE TENTH CIRCUIT DECISION 6

REASONS FOR DENYING CERTIORARI 8

A. PETITIONERS' EIGHTH AMENDMENT CHALLENGE FAILS TO PRESENT A COMPELLING FEDERAL ISSUE OR CONFLICT OF FEDERAL LAW THAT WARRANTS RESOLTUION BY THIS COURT CONCLUSION 8

B. PETITIONERS' REQUEST AMOUNTS TO A REQUEST FOR THIS COURT TO SUBSTITUTE ITS JUDGMENT FOR THE DISTRICT COURT'S FINDINGS OF FACT AND CREDITBILITY DETERMINATIONS 9

C. THE TENTH CIRCUIT'S APPLICATION OF THE *BAZE* STANDARD IS PROPER 10

CONCLUSION 11

TABLE OF AUTHORITIES

Anderson v. City of Bessemer City, N.C.,
470 U.S. 564 (1985) 9

Baze v. Rees,
553 U.S. 35 (2008) 3, 4, 7, 8, 9, 10, 11

Chavez v. Florida SP Warden,
742 F.3d 1267 (11th Cir. 2014) 8

Chavez v. Palmer,
134 S.Ct. 1156 (2014) 8

Muhammed v. Florida,
134 S.Ct. 894 (2014) 8

Warner et al. v. Gross, et al.,
2015 WL 137627 1

STATUTES

28 U.S.C. § 1254(1) 2

No. 14-7955

IN THE SUPREME COURT OF THE UNITED STATES

CHARLES F. WARNER; RICHARD E. GLOSSIP; JOHN M. GRANT; and BENJAMIN R. COLE, by and through his next friend, Robert S. Jackson,

Petitioners,

vs.

KEVIN J. GROSS; MICHAEL W. ROACH; STEVE BURRAGE; GENE HAYNES; FRAZIER HENKE; LINDA K. NEAL; EARNEST D. WARE; ROBERT C. PATTON and ANITA K. TRAMMELL,

Respondents.

CAPITAL CASE
EXECUTION OF CHARLES WARNER
SCHEDULED FOR 6:00 PM (CST)
THURSDAY, JANUARY 15, 2015

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

Respondents respectfully urge this Court to deny the petition for writ of certiorari to review the published opinion of the United States Court of Appeals for the Tenth Circuit, entered in this case on January 12, 2015, *Warner. v. Gross*, 2015 WL 137627.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A) is reported at ___ F.3d ___, 2015 WL 137627. The district court's ruling denying Petitioners' Motion for Preliminary Injunction is not reported.

JURISDICTION

The judgment of the court of appeals was entered on January 12, 2015. The petition for writ of certiorari was filed on January 14, 2015. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

PROCEDURAL HISTORY

Petitioners are death row inmates set for execution on January 15, 29, February 19, and March 5, 2015. (Dist. Ct. ECF No. 71-1). The Tenth Circuit noted that Petitioner Warner raped and murdered an eleventh month-old baby, Petitioner Glossip arranged for the beating death of his employer, Petitioner Grant stabbed a correction worker to death, and Petitioner Cole bent his nine month-old daughter in half, breaking her spine, killing her. (Pet. App. A at 3-4). Petitioners filed suit against Respondents in their official capacity on June 25, 2014, challenging the constitutionality of the execution protocol of the Oklahoma Department of Corrections ("ODOC"). Petitioners sought declaratory and injunctive relief. (Dist. Ct. ECF No. 75).

Petitioners claimed that the execution protocol would violate the Eighth Amendment by (1) executing Petitioners with the same drugs and procedures used in a previous execution, (2) using midazolam in Petitioners' executions, (3) would violate the Eighth Amendment by using compounded drugs in Petitioners' executions, (4) would violate the Eighth Amendment by using unsound procedures and inadequate training, (5) would violate due process and access to courts by not providing proper notice regarding how Petitioners would be executed, (6) would violate *ex post facto*, (7) would violate the Eighth Amendment by conducting human experimentation, and (8) would violate Petitioners' access to courts, counsel, and government. *Id.*

Over five (5) months after initiating their lawsuit, Petitioners filed a motion for preliminary injunction on November 10, 2014, regarding claims 2, 4, 5, 7, and 8, requesting that

the District Court stay the four scheduled executions. (Dist. Ct. ECF No. 92). The district court provided wide latitude for Petitioners to pursue discovery, and then held a three-day hearing on Petitioners' motion, and determined that Petitioners failed to establish the elements required for a preliminary injunction. (Dist. Ct. ECF Nos. 172, 173 and 179). Petitioners then appealed that denial to the Tenth Circuit Court of Appeals, claiming that the District Court abused its discretion in denying Petitioners' motion for preliminary injunction. (Dist. Ct. ECF No. 176). Petitioners also filed a motion for a stay of execution at the Tenth Circuit. (10th Cir. ECF No. 01019367079, filed Jan. 8, 2015).

The Tenth Circuit affirmed the district court, finding that the district court did not abuse its discretion in denying Petitioners' requested preliminary injunction. Petitioners then filed their petition for a writ of certiorari in this Court.

STATEMENT OF THE CASE

Petitioners request that this Court revisit *Baze v. Rees*, not because of a circuit split, not on account of misapplications of *Baze*, but merely because they disagree with the consistent results that have stemmed from the *Baze* decision. While Petitioners claim "multiple malfunctioning executions," it is undisputed that Oklahoma's protocol, which is identical to Florida's protocol, has been used 10 times in executions without serious incident.[1] Petitioners can only cite to executions that took place using different drug combinations, or the Oklahoma execution of Offender Lockett, in which IV access was subsequently found to be insufficient and

[1] The record below reflects that Florida has used this method 11 times. However, Respondents have only been able to determine that Florida has used the method 10 times.

flawed.[2] This leaves Petitioners with no basis for revisiting *Baze* in this case, other than the obvious basis: Petitioners' claims cannot succeed under this Court's established precedent.

A. OKLAHOMA'S EXECUTION PROTOCOL

The State of Oklahoma will execute Petitioners using an execution protocol which utilizes 500 milligrams of midazolam, 100 milligrams of rocuronium bromide, and 240 milliequivalents of potassium chloride. Midazolam is a sedative that renders the offender unconscious, after which the other two drugs are injected, causing death. This particular method has been implemented in the State of Florida 10 times, but has not yet been used in Oklahoma.[3]

B. OKLAHOMA'S CHOICE OF MIDAZOLAM

As several courts, including the district court, have noted, states that employ capital punishment by lethal injection have struggled to obtain the necessary chemicals to conduct executions, largely due to political or extra-legal pressures exerted by opponents of the death penalty. As a result of this war of attrition, the selection of drugs available to the states has dwindled. Still, the State of Oklahoma always attempts to obtain and employ the most humane drugs available. While Petitioners decry the State's process for choosing midazolam, and allege all manner of dastardly reasons for that choice, the State chose midazolam because it had been shown to work, and work effectively. Florida has established an impressive track record of successful executions using midazolam. That fact alone makes that method a logical and workable choice, especially since, unlike sodium thiopental and pentobarbital, midazolam was actually available. As a result, Oklahoma chose to emulate Florida's method going forward, as long as sodium thiopental and pentobarbital remain unavailable. Contrary to Petitioners'

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[2] The State of Oklahoma also used 100 milligrams of midazolam, as opposed to the 500 milligrams now required by the protocol.

[3] The State has used a three-drug protocol using midazolam once, in the Lockett execution. However, that protocol only used 100 milligrams of midazolam, one-fifth of the amount designated in the current protocol.

breathless accusations of convenience and political expediency, Oklahoma chose midazolam because the State has a sacred duty to enforce its criminal judgments, and the protocol pioneered by Florida represents the best available mechanism to carry out these judgments.

C. THE DISTRICT COURT DECISION

In June of 2014, Petitioners filed their lawsuit, challenging Oklahoma's execution protocol. (Dist. Ct. ECF No. 1). The protocol was revised on September 30, 2014, following an in-depth investigation by the Oklahoma Department of Public Safety into the execution of Offender Lockett. (Dist. Ct. ECF No. 55). Petitioners filed an Amended Complaint, but still did not file a motion for preliminary injunction until early November 10, 2014, only after the district court set a deadline for them to request a stay. (Dist. Ct. ECF Nos. 75, 79, 92). In preparation for the hearing, Respondents and other state agencies provided over 15,000 pages of documents in discovery. (Dist. Ct. ECF No. 149). Petitioners misquote and misstate a key issue of the district court's opinion. Petitioners state that the district court did find that the use of midazolam increases the risk of pain. This is a misrepresentation, as the district court only acknowledged that there *may* be some greater risk. (Pet. App. C at 44:25-45:7). The district court stopped short of finding that there was a greater risk created by Oklahoma's execution protocol. Also, Petitioners fail to acknowledge that the possible risk was referenced in comparison to the two unavailable drugs, not in comparison to any alternatives actually available.

In fact, the district court acknowledged that a court is not to sit as a "board of inquiry charged with determining best practices for executions," and noted that any asserted risk regarding midazolam was cured by the fact that Oklahoma's protocol required primary and secondary IV lines, required confirmation of the viability of IV sites, and required that the offender's consciousness level be monitored throughout the procedure. *Id.* at 45:14-18, 66:1-19.

Furthermore, the district court determined that Petitioners had failed to show that there was a known and available alternative to the method chosen by the State of Oklahoma. *Id.* 66:25-67:10. In reaching that conclusion, the district court relied on authority from the Eighth, Fifth, and Sixth Circuit Courts of Appeal. *Id.* at 67:11-69:5. The district court accordingly denied Petitioners' request for a preliminary injunction, and Petitioners appealed to the Tenth Circuit.

D. THE TENTH CIRCUIT DECISION

The Tenth Circuit reviewed the district court's ruling under the proper abuse of discretion standard. The Tenth Circuit reviewed the district court's factual findings in depth, and was unable to "say that any of these factual findings are clearly erroneous, despite Petitioners' voracious attack on the State's expert witness, Dr. Lee Evans." *Id.* at 27. The Tenth Circuit was careful to note that Petitioners did not actually claim that the district court failed to make adequate *Daubert* findings regarding Dr. Evans' testimony. *Id.* at 25. Instead, Petitioners focused on ancillary mistakes by Dr. Evans that the Tenth Circuit determined did *not* "seriously undercut the key portions of Dr. Evans' testimony that were relied on by the district court." *Id.* at 27.

While the Tenth Circuit spent a significant amount of time addressing Petitioners' strident smear campaign against Dr. Evans, the Tenth Circuit also addressed the inaccuracies in Petitioners' misguided legal theory. *Id.* at 18. The Tenth Circuit first rejected Petitioners' argument that they have no obligation to show that a known and readily available alternative to the State's protocol exists. *Id.* at 19-20. The Tenth Circuit observed that the Circuit's own precedent, which Petitioners noticeably failed to reference, foreclosed that argument. *Id.* at 19-20, 19 n.8. The Tenth Circuit further noted that the Eight Circuit is in agreement with the Tenth, and that this Court has never indicated that the approach is in error. *Id.* at 20, 20 n. 9. The Tenth

Circuit then rejected Petitioners' argument that the standards in *Baze* were somehow inapplicable to the current case, as the *Baze* standard was applicable to "all challenges to 'a State's chosen procedure for carrying out a sentence of death.'" *Id.* at 21 (citing *Baze v. Rees*, 553 U.S. 35, 48 (2008)).

The Tenth Circuit also rejected Petitioners' arguments that the district court should not have relied on the requirements of primary and secondary IV lines, the required confirmation of the viability of IV sites, and the requirement that the offender's consciousness level be monitored throughout the procedure. *Id.* The Tenth Circuit recognized, in spite of Petitioners' conflation of the issues, that the district court's reliance on those factors went not to the inherent characteristics of midazolam, but to the risk of improper administration. *Id.* Finally, the Tenth Circuit rejected Petitioners' claims that reports of prisoner movements in the Florida executions rendered the protocol objectively intolerable under evolving standards of decency. *Id.* at 21-22. The Tenth Circuit noted that "[n]othing in *Baze*...supports these arguments." *Id.* at 22.

The Tenth Circuit rejected Petitioners claims and affirmed the district court. As a final note, at the Tenth Circuit, Petitioners sought to bolster their arguments from the district court by submitting "declarations" or "reviews" from their experts, attempting to affect a sort of post-hearing, hearsay impeachment of the State's expert witness, and have repeated this misplaced attempt now in this Court. (Pet. Apps. F, G). These two hearsay-ridden affidavits, created and presented outside of the fact-finding process, (never subjected to proper cross-examination by opposing counsel herein or to any review at all by the district court and his own inquiry), are wholly improper and suggest that these Petitioners, rather than being interested in efficient and proper administration of justice, seek only to distract from the facts and legal issues properly before the courts.

REASONS FOR NOT GRANTING THE WRIT

Petitioners' current action appears to be little more than yet another successive habeas action, one to which they should not be entitled in the first place. Petitioners attempt to frame the current capital punishment situation as something new, novel, or ground-breaking. This is inaccurate. As noted several times, this particular method of execution has been examined in state and federal courts in the State of Florida. *Chavez v. Florida SP Warden*, 742 F.3d 1267 (11th Cir. 2014); *Muhammad v. Florida*, 132 So.3d 176 (Fla. 2013). This Court has already had the opportunity to weigh in on this particular protocol twice, and has declined to do so each time. *Muhammed v. Florida*, 134 S.Ct. 894 (2014); *Chavez v. Palmer*, 134 S.Ct. 1156 (2014). In fact, it appears that Florida's protocol is so well-established that an inmate scheduled for execution in Florida on January 15, 2015, has not even filed a challenge to Florida's method.

Further, Petitioners seem to find fault with states (and their legal counsel) using *Baze* as a guide in crafting execution protocols, as if relying on this Court's precedent to fulfill their constitutional duties is somehow nefarious or unseemly. Finally, Petitioners claim this Court must give "urgently needed guidance." This statement is particularly unsupported, considering courts have been remarkably consistent in their application of the *Baze* standard, demonstrating that the standard is clear, consistent, and understood. The only inconsistency which exists in this case arises from Petitioners' own miscomprehensions regarding the requirements of *Baze*, which they flatly refused to comply with at the district court.

A. PETITIONERS' EIGHTH AMENDMENT CHALLENGE FAILS TO PRESENT A COMPELLING FEDERAL ISSUE OR CONFLICT OF FEDERAL LAW THAT WARRANTS RESOLUTION BY THIS COURT.

Petitioners fail to point to any instance where the circuit courts of appeal are in disagreement concerning what *Baze* requires. Petitioners also fail to point out any inconsistency

among courts regarding how they interpret or apply *Baze*. In addition, this Court has had numerous opportunities since deciding *Baze* to clarify any misapplication by lower courts, and has in every instance declined to address the issue. The historical consistency with which multiple and varying courts have applied the *Baze* standard is evidence enough that the standard is reliable and clear.

In addition to a lack of conflict regarding *Baze*, there is no compelling federal issue implicated by this matter. While Petitioners make much of the evolving execution protocols, the bedrock inquiry has not changed. Under *Baze*, a protocol is constitutional unless there is a demonstrated risk of serious harm that is substantial when compared to the known and available alternatives. *Baze*, at 61. Petitioners try to limit that standard to only protocols that are similar to the protocol in *Baze*, but *Baze* is much broader, and encompasses every method that a state uses to enforce capital sentences. The very reason that *Baze* has endured without conflict as to its interpretation is that the standard is clear and applicable in every situation. No matter how a state might change its protocol, they must conform the protocol to the *Baze* standard.

B. PETITIONERS' REQUEST AMOUNTS TO A REQUEST FOR THIS COURT TO SUBSTITUTE ITS JUDGMENT FOR THE DISTRICT COURT'S FINDINGS OF FACT AND CREDIBILITY DETERMINATIONS.

Disagreement with the factual findings of a district court is an insufficient basis for appeal. This Court has held that "if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently." *Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 573-74 (1985). The district court's account of the evidence is more than plausible. However, while not explicitly claiming that the district court was factually in error, Petitioners claim that this protocol is different than the protocol in *Baze* because midazolam cannot reliably create a deep, coma like

unconsciousness. This is, in fact, a factual contention that attacks the heart of the district court's findings. The district court determined that the administration of 500 milligrams of midazolam made it a "virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs." (Pet. App. C at 42:4-8). Therefore, any claim that there is a difference between the *Baze* protocol and Oklahoma's protocol is a challenge to the district court's finding of fact, and is a distinction without a difference. The district court's factual determinations were clearly plausible and in accordance with *Baze*. Any challenge to those determinations made by the district court, therefore, is improper as a basis of appeal and is unwarranted under the applicable legal and factual standards.

C. THE TENTH CIRCUIT'S APPLICATION OF THE *BAZE* STANDARD IS PROPER.

Petitioners claim that the Tenth Circuit's requirement that they show a known and available alternative is not consistent with the evolving standards of decency precedents of this Court. Petitioners claim that the Tenth Circuit requires this showing even if the method of execution is unconstitutional. This allegation shows Petitioners' clear lack of understanding of this Court's Eighth Amendment jurisprudence. As this Court has observed many times, capital punishment is constitutional, therefore states *must* have a way to carry out that punishment. *Baze*, at 47. Therefore, alternative availability is a key component to whether a method is unconstitutional or not. This Court's ruling in *Baze* makes it clear that constitutionality is evaluated according to what methods are available, not according to hypothetical methods that are unavailable. Under *Baze*, the only way to evaluate whether a method of execution is constitutional is to determine whether other available methods significantly reduce a demonstrated risk of serious harm that exists with the challenged method. Therefore, there could

be no situation where a method of execution is per se unconstitutional *without* reference to alternatives, except in the specific case of torturous methods specifically listed in *Baze* or methods that are utilized for the express purpose of inflicting pain. A known and available alternative is a necessary tool that allows courts to determine whether an execution method is constitutional. Without that constraint, any number of absurd situations could be contemplated, where condemned inmates argue that the only proper method of execution would be an impossible or non-existent option thereby effectively thwarting the death penalty.

By asking this Court to not require that showing, Petitioners seek to hamstring reviews of protocols, and set themselves or the courts up as boards of inquiry, determining best practices for executions. This is an untenable and unworkable proposal, and should be rejected by this Court.

CONCLUSION

The petition for writ of certiorari should be denied, and Petitioners' accompanying motion for stay of execution, should be denied. The determinations of the Tenth Circuit and the district court should be affirmed.

Respectfully submitted,

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No. 14-7955

IN THE SUPREME COURT OF THE UNITED STATES

Charles F. Warner; Richard E. Glossip; John M. Grant; and Benjamin R. Cole, by and through his next friend, Robert S. Jackson, Petitioners,

vs.

Kevin J. Gross, Michael W. Roach, Steve Burrage, Gene Haynes, Frazier Henke, Linda K. Neal, Earnest D. Ware, Robert C. Patton, and Anita K. Trammell, Respondents.

*****CAPITAL CASE*****
EXECUTION OF CHARLES WARNER
SCHEDULED FOR 6:00 PM (CST)
THURSDAY, JANUARY 15, 2015

REPLY TO BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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REPLY TO BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Petitioners have presented this Court with questions of national significance—questions that courts of appeals have been asked to address in the absence of this Court's guidance. Whether states may use a lethal-injection protocol that is pharmacologically and constitutionally far removed from the protocol the Court approved in *Baze v. Rees*, 553 U.S. 35, 44 (2008), is an issue of national importance. *See* Sup. Ct. R. 10(c). Whether the courts have the proper tools to carefully evaluate these experimental protocols that use constitutionally suspect drugs also is a matter of national importance. *See* Sup. Ct. R. 10(c). And, whether states are entitled to execute prisoners in an unconstitutional manner if the prisoners are unable to design and recommend an alternative drug formula to the government is a matter of national importance as well. *See* Sup. Ct. R. 10(c).

Yet despite Petitioners' explanation of these *novel* issues—issues that transport the current execution landscape beyond *Baze*'s well-established safe harbor—Respondents claim this Court's attention is unnecessary because Petitioners "disagree with results that have stemmed from the *Baze* decision." (Brief in Opp'n to Pet. Writ Cert. at pdf page 7/16.) But "results" that address a drug pharmacologically unable to meet *Baze*'s requirements do not and cannot "stem from" *Baze*.

Instead, as Petitioners have demonstrated through testimony of practicing medical doctors, and supported with medical and scientific studies, *no* dose of midazolam can comply with *Baze*'s requirement of a drug that creates a "deep, comalike unconsciousness." 553 U.S. at 44. Respondents' reliance on a dose increased from the amount used in the execution of Clayton Lockett (Br. in Opp'n at pdf page 9/16 nn. 2 & 3) does not salvage the protocol's constitutionality, because, as Arizona's execution of Joseph Wood demonstrated, midazolam's ceiling effect means that a larger dose cannot have a greater effect. The Wood execution, which used 750 mg of midazolam—250 mg more than that required in Oklahoma's execution protocol—resulted in Mr. Wood gasping and struggling to breathe for nearly two hours before he finally died.

Equally irrelevant is Respondents' argument, and the Tenth Circuit's holding, that Oklahoma's protocol is constitutional because it added procedures relating to intravenous lines and "consciousness checks" (of the type addressed in *Baze*, 553 U.S. at 55-56). These measures are irrelevant because *no dose* of midazolam can reliably produce the deep, comalike unconsciousness that *Baze* requires.

But because this Court has not addressed lethal-injection protocols that are removed from the *Baze* landscape, the Tenth Circuit and other circuits have had to

address these questions in light of *Baze*[1]—a decision that could not have addressed the states' novel approaches to execution protocols. Indeed, the Tenth Circuit stated that it would continue to do so "absent superseding . . . Supreme Court decisions." (App. A at 20.)

Respondents misconstrue the absence of this Court's previous decisions not to review *Baze*-related questions. (Br. in Opp'n at pdf pages 13/16) (asserting that "this Court has had numerous opportunities since deciding *Baze* to clarify any misapplication by lower courts, and has in every instance declined to address the issue"). While the Court's decision to decline review in a case "imports no expression of opinion upon the merits of the case," *United States v. Carver*, 260 U.S. 482, 490 (1923), Respondents ignore the fact that the Court has not been asked to address the constitutionality of these novel drugs; nor has it been asked to resolve questions about the changed landscape since *Baze*. The fact that the Court has not previously reviewed its decision in *Baze* supports rather than undercuts Petitioners' argument that the time has come for the Court to provide necessary guidance.

Respondents argue that because "Florida has established an impressive track record of successful executions using midazolam[,] [t]hat fact alone makes that

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[1] As Petitioners explained (Pet. Writ Cert. at 23), the Tenth Circuit's decision in *Powell v. Jones*, 627 F.3d 1336 (10th Cir. 2010), which related to a lethal-injection protocol using a barbiturate similar to sodium thiopental, addressed matters that existed as part of the original *Baze* landscape. (*Cf.* Br. in Opp'n at pdf page 10/16.)

method a logical and workable choice . . " (Br. in Opp'n at pdf page 8/16.) But "logical and workable" are not proper Eighth Amendment standards; neither is a "me too!" approach. Moreover, as Petitioners have explained, "availability" does not equal "constitutional." (Pet. Writ Cert. at 23.) These cannot be the measures by which states assert compliance with the Eighth Amendment, and this Court should not countenance such an approach.

Respondents also rely on the assertion that Florida has used its protocol—the one that Oklahoma now intends to use—ten times "without serious incident." (Br. in Opp'n at pdf page 7/16.) Respondents not only do not explain what the phrase "without serious incident" means, but they also fail to account for the manner in which the paralytic masks (when properly administered, unlike the situation in Oklahoma's execution of Clayton Lockett) effects of any other aspect of the execution. But absence of evidence is *not* evidence of absence. Conversely, Petitioners have offered medical and scientific data, as well as data obtained from the three executions that did not include a paralytic (either by accident or design), and that thus exposed the true effects (or, rather, lack thereof) of midazolam on condemned prisoners.

Finally, Respondents claim that Oklahoma has a "sacred duty to enforce its criminal judgments." (Br. in Opp'n at pdf page 9/16.) But this "sacred duty" includes the Eighth Amendment requirement that Oklahoma carry out its criminal

judgments *in a constitutional manner*. The State is entitled to execute prisoners (including Petitioners) only in a constitutional manner, and without regard to the underlying facts of their conviction. Respondents cannot use the facts of a conviction as justification to obliterate constitutional protections, nor as justification to short-circuit constitutional review.

CONCLUSION

Accordingly, Petitioners respectfully ask that this Court grant the petition for writ of certiorari, review Oklahoma's use of midazolam in its lethal-injection protocol, and provide the guidance that courts, states, and prisoners need as they navigate this lethal-injection terrain.

Respectfully submitted: January 14, 2015.

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No. 14-7955

IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

JOINT APPENDIX – VOLUME I

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TABLE OF CONTENTS

	Page
United States District Court for the Western District of Oklahoma, No. 5:14-cv-665, Relevant Docket Entries	1
United States Court of Appeals for the Tenth Circuit, No. 14-6244, Relevant Docket Entries	22
Motion in Limine, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 15, 2014), ECF No. 161	34
Order Denying Motion for Preliminary Injunction, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 22, 2014), ECF No. 173	41
Transcript of Court's Ruling, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 22, 2014)	43
Opinion, *Warner* v. *Gross*, No. 14-6244 (10th Cir. Jan. 12, 2015)	111
Stay of Execution Order, *Glossip* v. *Gross*, No. 14-7955 (U.S. Jan. 28, 2015)	140
Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 18, 2014) (testimony of Oklahoma Department of Corrections, Former General Counsel, Michael Oakley)	141
Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17, 2014) (testimony of Warden Anita Trammell)	151
Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 19, 2014) (testimony of Director Robert Patton)	155

TABLE OF CONTENTS—continued

Page

Pls.' Ex. 80, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (report of David Lubarsky, M.D. (Nov. 26, 2014)) 168

Excerpt of Ex. 3 to Pls.' Ex. 80, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Hospira's Material Safety Data Sheet for Midazolam Hydrochloride Injection, Solution with Preservative) 179

Excerpt of Ex. 4 to Pls.' Ex. 80, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Paradoxical Reactions to Benzodiazepines by Mary A. Gutierrez, Pharm.D., Janice M. Roper, PhD, RN, and Pockhee Hahn, RN)..... 184

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17, 2014) (testimony of Dr. Lubarsky) 199

Ex. 4 to Appellants' Emergency Motion for Stays of Executions, *Warner* v. *Gross*, No. 14-6244 (10th Cir. Jan. 8, 2015), ECF No. 10238498 (Declaration of David Lubarsky, M.D.) 232

Pls.' Ex. 77, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (report of Larry Sasich, Pharm.D.)..... 238

Excerpt of Ex. 2 to Pls.' Ex. 77, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (FDA-approved professional product label for midazolam) 250

TABLE OF CONTENTS—continued

Page

Excerpt of Ex. 4 to Pls.' Ex. 77, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (FDA-approved professional product label for potassium chloride) 253

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 18, 2014) (testimony of Larry Sasich) 256

Ex. 5 to Appellants' Emergency Motion for Stays of Executions, *Warner* v. *Gross*, No. 14-6244 (10th Cir. Jan. 8, 2015), ECF No. 10238498 (Review of the Expert Report and Oral Testimony of R. Lee Evans) 274

Excerpt of Ex. 2 to Pls.' Ex. 77, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (FDA-approved professional product label for midazolam) 285

Defs.' Ex. 34, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Dr. R. Lee Evans Expert Report) 293

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 19, 2014) (testimony of R. Lee Evans, Pharm.D.) 304

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 19, 2014) (testimony of Eric Katz, M.D.) 336

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17, 2014) (testimony of Joseph Cohen, M.D.) 343

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17, 2014) (testimony of David Autry) 348

TABLE OF CONTENTS—continued

Page

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17, 2014) (testimony of Lisbeth Exon) 352

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 18, 2014) (testimony of Scott Crow) 359

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 19, 2014) (testimony of Joni McClain) 370

Pls.' Ex. 65, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Executive Summary: The Execution of Clayton Locket, Case No. 14-0189SI (Sept. 4, 2014)) 376

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 18, 2014) (testimony of Captain Jason Holt) 420

Excerpt of Transcript, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 19, 2014) (closing arguments) 426

Amended Petition for Declaratory Relief and Request for Injunction, *Lockett* v. *Evans*, No. cv-14-330 (Dist. Ct. Okla. Cnty. Mar. 7, 2014) 431

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF OKLAHOMA
OKLAHOMA CITY

5:14-cv-00665-F

WARNER, ET AL.,

v.

GROSS, ET AL.,

RELEVANT DOCKET ENTRIES

DATE	NO.	PROCEEDINGS
06/25/2014	1	COMPLAINT against All Defendants filed by All Plaintiffs. (Attachments: # 1 Attachment 1 – List of Plaintiffs, # 2 Attachment 2 – List of Plaintiffs Attorneys, # 3 Exhibit 3 – List of Defendants, # 4 Civil Cover Sheet)(cpp) (Entered: 06/25/2014)
	* * * *	
07/16/2014	40	MOTION to Dismiss *and Brief in Support* by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Michael W Roach, Earnest D Ware. (Attachments: # 1 Exhibit Executive Order 2014–11, # 2 Exhibit Executive Order

DATE	NO.	PROCEEDINGS
		2014–10, # 3 Exhibit Death Row Report, # 4 Exhibit OSP–040401–01, # 5 Attachment Benevides v City of OKC (unpubished case), # 6 Attachment Lockett v Evans (unpublished case))(Hadden, John) (Entered: 07/16/2014)
07/16/2014	41	ANSWER to Complaint by Robert C Patton, Anita K Trammell.(Hadden, John) (Entered: 07/16/2014)
07/16/2014	42	MOTION to Stay Case *and Brief in Support* by Robert C Patton, Anita K Trammell. (Attachments: # 1 Exhibit Death Row Report, # 2 Exhibit Executive Order 2014–11, #3 Exhibit Executive Order 2014–10)(Hadden, John) (Entered: 07/16/2014)
	*	* * *
08/06/2014	45	RESPONSE to Motion re 42 MOTION to Stay Case *and Brief in Support*, 40 MOTION to Dismiss *and Brief in Support* filed by All Plaintiffs. (Attachments: # 1 Exhibit 1) Board of Corrections Policy P–040100, # 2 Exhibit 2) Dept of Corr Operating Policy P–040301, # 3 Exhibit 3) OSP Policy

DATE	NO.	PROCEEDINGS
		OSP–040301, # 4 Exhibit 4) Addendum to OSP–040301, # 5 Exhibit 5) BOC Minutes 5–14–10, # 6 Exhibit 6) BOC Minutes 6–18–10, # 7 Exhibit 7) BOC Minutes 10–22–10, # 8 Exhibit 8) BOC Minutes 10–21–11, # 9 Exhibit 9) BOC Minutes 5–1–14, # 10 Exhibit 10) BOC Minutes 6–5–14, # 11 Exhibit 11) BOC Minutes 4–25–13, # 12 Exhibit 12) BOC Minutes 4–3–14)(Ghezzi, Patti) (Entered: 08/06/2014)
8/12/2014	46	ORDER Setting Hearing on 42 MOTION to Stay Case *and Brief in Support*: Motion Hearing set for 9/18/2014 09:00 AM in Courtroom 305 before Honorable Stephen P. Friot (as fully set out in this order). Signed by Honorable Stephen P. Friot on 8/12/14. (llg) (Entered: 08/12/2014)
8/13/2014	47	REPLY to Response to Motion re 40 MOTION to Dismiss *and Brief in Support*, 42 MOTION to Stay Case *and Brief in Support* filed by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell Earnest D Ware.

DATE	NO.	PROCEEDINGS
		(Hadden, John) (Entered: 08/13/2014)
09/09/2014	48	ORDER. Ct notes that a report entitled "The Execution of Clayton Lockett," Case No. 14–0189SI, has been rendered by Okla DPS. To facilitate the ct's consideration of, among other things, the mtns that are now pndg in this action (&to facilitate any necessary consideration of the matter by a reviewing ct), dfts Patton &Trammell are DIRECTED to file a copy of that report in this action by 9/26/14. That filing shall be accompanied by a representation, by counsel for dfts, as to whether dfts Patton or Trammell believe that Part III of the report (pp. 8–25) contains any materially incorrect factual stmts. If there are any such stmts believed by dfts Patton or Trammell to be materially incorrect, dfts' filing shall itemize them, &may provide such addl explanation as those dfts shall consider to be appropriate or advisable. Signed by Honorable Stephen P. Friot on 9/9/14. (llg) (Entered: 09/09/2014)

DATE	NO.	PROCEEDINGS
09/16/2014	49	RESPONSE TO ORDER TO SHOW CAUSE filed by All Defendants. (Attachments: # 1 Exhibit DPS Report)(Hadden, John) (Entered: 09/16/2014)
09/18/2014	50	Minute Order. Proceedings held before Honorable Stephen P. Friot: Motion Hearing held on 9/18/2014. 42 MOTION to Stay Case *and Brief in Support* filed by Robert C Patton, Anita K Trammell is DENIED. (Court Reporter Jeanne Ring.) (llg) (Entered: 09/18/2014)
	*	* * *
09/30/2014	54	ORDER denying 40 Defendants' Motion to Dismiss. Signed by Honorable Stephen P. Friot on 9/30/14. (llg) (Entered: 09/30/2014)
10/01/2014	55	NOTICE (other) by Oklahoma Department of Corrections (Attachments: # 1 Exhibit OP–040301 – Execution of Offenders Sentenced to Death) (Hadden, John) (Entered: 10/01/2014)
10/08/2014	56	ENTER ORDER. Status Conference set for 10/15/2014 01:30 PM in Chambers before Honorable Stephen P. Friot. Entered at the direction of

DATE	NO.	PROCEEDINGS
		Honorable Stephen P. Friot on 10/8/14. (llg) (Entered: 10/08/2014)
	*	* * *
10/10/2014	58	*BRIEF IN SUPPORT* re 56 Order, Set Hearings *Plaintiffs' Memorandum of Law* by All Plaintiffs. (Attachments: # 1 Exhibit 1) Aff of Anita Trammell)(Ghezzi, Patti) (Entered: 10/10/2014)
10/10/2014	59	SECOND MOTION to Dismiss *and Brief in Support* by Steve Burrage, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Hadden, John) (Entered: 10/10/2014)
10/10/2014	60	ANSWER to Complaint by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware.(Hadden, John) (Entered: 10/10/2014)
	*	* * *
10/14/2014	64	MOTION for Protective Order *and Brief in Support* by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda

DATE	NO.	PROCEEDINGS
		K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Attachments: # 1 Exhibit OP–060212 – Maintenance &Access of Offender Records, # 2 Exhibit OP–140108 – Privacy of Protected Health Information, # 3 Exhibit Proposed Protective Order, # 4 Exhibit Apothoecarry Email, # 5 Exhibit Complaint in Taylor v. Apothocare Shoppe, # 6 Exhibit Woodlands Letter) (Stewart, Aaron) (Entered: 10/14/2014)
10/15/2014	65	MOTION for Contempt *and Other Relief* by All Plaintiffs. (Attachments: # 1 Exhibit Subpoena 9–23–14, # 2 Exhibit Letter to DPS 5–23–14, # 3 Exhibit Letter of Objection) (Ghezzi, Patti) (Entered: 10/15/2014)
	*	* * * *
10/21/2014	68	RESPONSE in Opposition re 64 MOTION for Protective Order *and Brief in Support* filed by All Plaintiffs. (Attachments: # 1 Exhibit Opinion, # 2 Exhibit Protective Order, # 3 Exhibit Protective Order)(Ghezzi, Patti) (Entered: 10/21/2014)

DATE	NO.	PROCEEDINGS
	*	* * *
10/29/2014	74	SUPPLEMENTAL BRIEF IN SUPPORT OF MOTION for Protective Order *and Brief in Support* by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Attachments: # 1 Exhibit Plaintiffs' Requests for Production, # 2 Exhibit Plaintiff's 1st Set of Interrogatories to Defendant Trammell, # 3 Exhibit Death Row Statistics)(Hadden, John) Modified on 10/30/2014 (llg). (Entered: 10/29/2014)
	*	* * *
10/31/2014	75	AMENDED COMPLAINT against All Defendants filed by All Plaintiffs.(Ghezzi, Patti) (Entered: 10/31/2014)
10/31/2014	76	RESPONSE to Motion re 59 SECOND MOTION to Dismiss *and Brief in Support* filed by All Plaintiffs. (Ghezzi, Patti) (Entered: 10/31/2014)
11/03/2014	77	ORDER Setting Hearing on 64 Defendants' MOTION for Protective Order *and Brief in Support*, 65 Plaintiffs'

DATE	NO.	PROCEEDINGS
		MOTION for Contempt *and Other Relief*, 66 Plaintiffs' MOTION for Contempt *and Other Relief*: Motion Hearing set for 11/13/2014 01:30 PM in Courtroom 305 before Honorable Stephen P. Friot. Signed by Honorable Stephen P. Friot on 11/3/14. (llg) (Entered: 11/03/2014)
11/03/2014	78	ORDER striking as moot 59 Defendants' Second Motion to Dismiss, based on the filing of the Amended Complaint. Signed by Honorable Stephen P. Friot on 11/3/14. (llg) (Entered: 11/03/2014)
11/04/2014	79	PRELIMINARY SCHEDULING ORDER. Any mtn for preliminary injunction shall be filed by 11/10/14. A mtn for preliminary injunction filed after that date may be stricken. The mtn need not be supported by a brief, because the court will, if a mtn for preliminary injunction is timely filed, enter a scheduling order which will include a provision for the filing of trial briefs &proposed findings of fact &conclusions of law in advance of the hrg on the mtn for preliminary injunction.

DATE	NO.	PROCEEDINGS
		However, the mtn for preliminary injunction must state precisely &in detail the nature & scope of the preliminary injunctive relief sought. Signed by Honorable Stephen P. Friot on 11/4/14. (llg) (Entered: 11/04/2014)
	*	* * *
11/05/2014	82	RESPONSE in Opposition re 74 SUPPLEMENTAL MOTION for Protective Order *and Brief in Support* filed by All Plaintiffs. (Ghezzi, Patti) (Entered: 11/05/2014)
	*	* * *
11/05/2014	86	RESPONSE to Motion re 65 MOTION for Contempt *and Other Relief* filed by Oklahoma State of. (Krise, Stephen) (Entered: 11/05/2014)
	*	* * *
11/05/2014	87	JOINT MOTION for Protective Order by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Stewart, Aaron) (Entered: 11/05/2014)

DATE	NO.	PROCEEDINGS
11/06/2014	88	SCHEDULING ORDER re PRELIMINARY INJUNCTION: Pla–Dft preliminary witness &exhibit lists &copies of exhibits to opposing counsel due 11/14/14; Pla disclose expert testimony by 11/26/14; Dft disclose expert testimony by 12/2/14; Pla–Dft final witness &exhibit lists &copies of addl exhibits to opposing counsel due 12/8/14; Discovery completion 12/10/14; Pla–Dft Proposed Findings of Fact and Conclusions due 12/12/14; Pla–Dft trial briefs due 12/12/14; Pretrial Conference 12/15/2014 at 01:30 PM; Hearing on application for preliminary injunction Dec. 17–19, 2014, at 09:00 AM. Signed by Honorable Stephen P. Friot on 11/6/14. (llg) (Entered: 11/06/2014)
	* * * *	
11/06/2014	90	AGREED PROTECTIVE ORDER. Signed by Honorable Stephen P. Friot on 11/6/14. (llg) (Entered: 11/06/2014)
	* * * *	
11/10/2014	92	MOTION for Preliminary Injunction by Benjamin R Cole,

DATE	NO.	PROCEEDINGS
		Richard E Glossip, John M Grant, Charles F Warner. (Ghezzi, Patti) (Entered: 11/10/2014)
11/13/2014	93	Minute Order. Proceedings held before Honorable Stephen P. Friot: Motion Hearing held on 11/13/2014. 65 MOTION for Contempt *and Other Relief* filed by Emmanuel A Littlejohn, James A Coddington, Nicholas A Davis, Tremane Wood, Wendell A Grissom, Richard S Fairchild, Phillip D Hancock, Kendrick A Simpson, Carlos Cuesta–Rodriguez, Julius D Jones, John M Grant, Kevin R Underwood, James D Pavatt, Brenda E Andrew, Alfred B Mitchell, Shelton D Jackson, Charles F Warner, Raymond E Johnson, Benjamin R Cole, Richard E Glossip, Marlon D Harmon is DENIED IN PART and GRANTED IN PART, as set out on the minute sheet & on the record. Status Conference set for 11/24/2014 09:00 AM in Courtroom 305 before Honorable Stephen P. Friot for the purpose of (i) ascertaining the status of the Commissioner's compliance with this order, &(ii) addressing the arrangements

DATE	NO.	PROCEEDINGS
		for the production of digitally stored emails. 64 MOTION for Protective Order *and Brief in Support* filed by Linda K Neal, Robert C Patton, Michael W Roach, Gene Haynes, Anita K Trammell, Earnest D Ware, Steve Burrage, Frazier Henke, Kevin J Gross is rendered MOOT IN PART, GRANTED IN PART and DENIED IN PART, as set out on the minute sheet &on the record. (Court Reporter Tracy Washbourne.) (llg) (Entered: 11/14/2014)
11/14/2014	94	ORDER memorializing the court's mandatory and prohibitory orders entered at 11/13/14 motion hearing re 64 MOTION for Protective Order *and Brief in Support*, 65 MOTION for Contempt *and Other Relief*. Follows oral order of 11/13/14. Signed by Honorable Stephen P. Friot on 11/14/14. (llg) (Entered: 11/14/2014)
	*	* * *
11/14/2014	96	ANSWER to 75 Amended Complaint by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael

DATE	NO.	PROCEEDINGS
		W Roach, Anita K Trammell.(Stewart, Aaron) (Entered: 11/14/2014)
11/14/2014	97	MOTION to Dismiss *Plaintiffs' Amended Complaint and Brief in Support* by Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Attachments: # 1 Exhibit Order Dismissing – Lockett v. Patton –O–2014–361, # 2 Exhibit Petition in Lockett v Patton – CV–14–637)(Stewart, Aaron) (Entered: 11/14/2014)
11/14/2014	98	Exhibit List / Witness List (*Preliminary*) by Defendants Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Stewart, Aaron) (Entered: 11/14/2014)
11/14/2014	99	Exhibit List / Witness List *Preliminary* by Plaintiffs Benjamin R Cole, Richard E Glossip, John M Grant, Charles F Warner (Ghezzi, Patti) (Entered: 11/14/2014)

* * * *

DATE	NO.	PROCEEDINGS
12/01/2014	117	RESPONSE to Motion re 92 MOTION for Preliminary Injunction filed by Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Attachments: # 1 Exhibit Attachment D to OP–040301, # 2 Exhibit OP–040301, # 3 Attachment Osborn v. Shillinger (unpublished table decision)) (Stewart, Aaron) (Entered: 12/01/2014)
	*	* * *
12/08/2014	128	Exhibit List / Witness List (*Final*) by Defendants Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Stewart, Aaron) (Entered: 12/08/2014)
12/08/2014	129	Exhibit List by Plaintiffs Brenda E Andrew, James A Coddington, Benjamin R Cole, Carlos Cuesta–Rodriguez, Nicholas A Davis, Richard S Fairchild, Richard E Glossip, John M Grant, Wendell A Grissom, Phillip D Hancock, Marlon D Harmon, Shelton D

DATE	NO.	PROCEEDINGS
		Jackson, Raymond E Johnson, Julius D Jones, Emmanuel A Littlejohn, Alfred B Mitchell, James D Pavatt, Kendrick A Simpson, Kevin R Underwood, Charles F Warner, Tremane Wood. (Ghezzi, Patti) (Entered: 12/08/2014)
12/08/2014	130	Witness List by Plaintiffs Brenda E Andrew, James A Coddington, Benjamin R Cole, Carlos Cuesta–Rodriguez, Nicholas A Davis, Richard S Fairchild, Richard E Glossip, John M Grant, Wendell A Grissom, Phillip D Hancock, Marlon D Harmon, Shelton D Jackson, Raymond E Johnson, Julius D Jones, Emmanuel A Littlejohn, Alfred B Mitchell, James D Pavatt, Kendrick A Simpson, Kevin R Underwood, Charles F Warner, Tremane Wood. (Ghezzi, Patti) (Entered: 12/08/2014)
	*	* * *
12/09/2014	141	SEALED DOCUMENT by Benjamin R Cole, Carlos Cuesta–Rodriguez, Nicholas A Davis, Richard S Fairchild, John M Grant, Wendell A Grissom, Marlon D Harmon, Raymond E Johnson,

DATE	NO.	PROCEEDINGS
		Emmanuel A Littlejohn, James D Pavatt, Kendrick A Simpson, Kevin R Underwood(Re: 139 Notice of Conventional Filing)(Rose, Kathy) (Entered: 12/10/2014)
	*	* * *
12/12/2014	155	ORDER denying 97 Motion to Dismiss. After careful consideration, defendants motion to dismiss is DENIED without prejudice to the possible re–urging of some of defendants arguments at another stage, if and when appropriate, with arguments carefully tailored to the evidence as it standsat that time. Signed by Honorable Stephen P. Friot on 12/12/14. (kr) (Entered: 12/12/2014)
	*	* * *
12/12/2014	157	Proposed Findings of Fact by Defendants Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke, Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Stewart, Aaron) (Entered: 12/12/2014)
12/12/2014	158	TRIAL BRIEF by Defendants Steve Burrage, Kevin J Gross, Gene Haynes, Frazier Henke,

DATE	NO.	PROCEEDINGS
		Linda K Neal, Robert C Patton, Michael W Roach, Anita K Trammell, Earnest D Ware. (Stewart, Aaron) (Entered: 12/12/2014)
12/12/2014	159	Proposed Findings of Fact by Plaintiffs Brenda E Andrew, James A Coddington, Benjamin R Cole, Carlos Cuesta-Rodriguez, Nicholas A Davis, Richard S Fairchild, Richard E Glossip, John M Grant, Wendell A Grissom, Phillip D Hancock, Marlon D Harmon, Shelton D Jackson, Raymond E Johnson, Julius D Jones, Emmanuel A Littlejohn, Alfred B Mitchell, James D Pavatt, Kendrick A Simpson, Kevin R Underwood, Charles F Warner, Tremane Wood. (Ghezzi, Patti) (Entered: 12/12/2014)
12/12/2014	160	TRIAL BRIEF *Preliminary Hearing Brief* by Plaintiffs Brenda E Andrew, James A Coddington, Benjamin R Cole, Carlos Cuesta-Rodriguez, Nicholas A Davis, Richard S Fairchild, Richard E Glossip, John M Grant, Wendell A Grissom, Phillip D Hancock, Marlon D Harmon, Shelton D Jackson, Raymond E Johnson,

DATE	NO.	PROCEEDINGS
		Julius D Jones, Emmanuel A Littlejohn, Alfred B Mitchell, James D Pavatt, Kendrick A Simpson, Kevin R Underwood, Charles F Warner, Tremane Wood. (Ghezzi, Patti) (Entered: 12/12/2014)
12/15/2014	161	MOTION in Limine *and Brief in Support* by All Plaintiffs. (Ghezzi, Patti) (Entered: 12/15/2014)
12/15/2014	162	Minute Order. Proceedings held before Honorable Stephen P. Friot: Pretrial Conference re Preliminary Injunction Hearing held on 12/15/2014. (Court Reporter Tracy Washbourne.) (llg) (Entered: 12/15/2014)
	*	* * *
12/19/2014	170	Minute Order. Proceedings held before Honorable Stephen P. Friot: Preliminary Injunction Hearing held on 12/17/2014, 12/18/2014 and 12/19/2014. 92 MOTION for Preliminary Injunction filed by John M Grant, Charles F Warner, Benjamin R Cole, Richard E Glossip is TAKEN UNDER ADVISEMENT. As to 168 *Objection to Sequestration Order and Request for Relief* filed by

DATE	NO.	PROCEEDINGS
		Ziva Branstetter, court rules that Ms. Branstetter will be permitted to remain in the courtroom. 165 MOTION to Quash *Subpoena* filed by Stephen J Krise, Michael Thompson is STRICKEN AS MOOT. Court will rule from the bench on the motion for preliminary injunction at 3:00 PM on 12/22/2014 in Courtroom 305. (Court Reporter Tracy Washbourne.) (llg) (Entered: 12/22/2014)
	*	* * *
12/22/2014	172	Minute Order. Proceedings held before Honorable Stephen P. Friot: Preliminary Injunction Hearing completed on 12/22/2014. 161 Plaintiffs' MOTION in Limine *and Brief in Support* as to the testimony of Dr. R. Lee Evans is DENIED. 92 MOTION for Preliminary Injunction filed by John M Grant, Charles F Warner, Benjamin R Cole, Richard E Glossip is without merit and is in all things DENIED. Brief written order to follow. Parties' exhibits are WITHDRAWN. (Court Reporter Tracy

DATE	NO.	PROCEEDINGS
		Washbourne.) (llg) (Entered: 12/22/2014)
12/22/2014	173	ORDER denying 92 MOTION for Preliminary Injunction. Follows oral order of 12/22/14. Signed by Honorable Stephen P. Friot on 12/22/14. (llg) (Entered: 12/22/2014)
12/23/2014	174	MOTION to Appoint Counsel by All Plaintiffs. (Ghezzi, Patti) (Entered: 12/23/2014)
	*	* * *
12/23/2014	176	NOTICE OF APPEAL as to 173 Order - Written Order Following Oral Order on Motion by Benjamin R Cole, Richard E Glossip, John M Grant, Charles F Warner. (Ghezzi, Patti) (Entered: 12/23/2014)
12/23/2014	177	ORDER granting 174 Motion to Appoint Counsel. Signed by Honorable Stephen P. Friot on 12/23/14. (kr) (Entered: 12/23/2014)
	*	* * *

UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

14-6244

WARNER, ET AL.,

v.

GROSS, ET AL.,

RELEVANT DOCKET ENTRIES

DATE	PROCEEDINGS
*	* * *
12/23/2014	[10235537] Prisoner case docketed. DATE RECEIVED: 12/23/2014. Docketing statement due 01/06/2015 for Charles F. Warner et al. Transcript order form due 01/06/2015 for Randy A. Bauman and Patti Palmer Ghezzi. Notice of appearance due on 01/06/2015 for Steve Burrage, Benjamin R. Cole, Edward Evans, Warden, Richard E. Glossip, John M. Grant, Kevin J. Gross, Gene Haynes, Frazier Henke, Linda K. Neal, Robert C. Patton, Michael W. Roach, Anita K.

DATE	NO.	PROCEEDINGS
		Trammell, Earnest D. Ware and Charles F. Warner. A/Pet designation of record due 01/06/2015 for Charles F. Warner et al. [14-6244]
12/23/2014		[10235554] Motion filed by Appellants Benjamin R. Cole, Richard E. Glossip and John M. Grant to expedite case. Served on: 12/23/2014. Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] PPG
12/24/2014		[10235606] Fee paid. Date paid in District Court on 12/24/2014. [14-6244]
12/24/2014		[10235635] Order filed by Clerk of the Court granting appellants' motion to expedite case. Appellant's brief due on 12/31/2014. Appellees' brief due 01/06/2015. Appellants' optional reply brief due 01/08/2015. Served on 12/24/2014. [14-6244]
	* * * *	
12/24/2014		[10235716] Designation of record filed by Appellants Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner. Served on

DATE	NO.	PROCEEDINGS
		12/24/2014. Manner of Service: email. [14-6244] PPG
12/24/2014		[10235728] Motion filed by Appellants Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner to supplement the record on appeal. Served on: 12/24/2014. Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes – [Edited 12/26/2014 by GH to upload attachments]. [14-6244] PPG
12/24/2014		[10235732] Record on appeal filed. No. of Volumes: 3, Comments: Vol 1- pleadings; Vol 2- sealed pleadings; Vol 3- transcripts. [14-6244]
12/26/2014		[10235740] Motion filed by Appellants Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner to supplement the record on appeal. Served on: 12/26/2014. Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [Edited 12/26/2014 by GH to upload attachments]. [14-6244] PPG

DATE	NO.	PROCEEDINGS
12/26/2014		[10235744] Docketing statement filed by Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner. Served on 12/26/2014. Manner of Service: email. [14-6244] PPG
12/29/2014		[10235846] Order filed by Clerk of the Court granting appellants' motions to supplement the record on appeal. The materials will be added as supplemental record volumes. Served on 12/29/2014. [14-6244]
12/29/2014		[10236282] Supplemental record on appeal filed. No. of Volumes: 31 (PLEASE NOTE: This supplemental record has been reconstituted into 31 volumes and has been redocketed). Supp. Vol. I: Exhibits 1-9, Supp. Vol. II: SEALED Exhibits 10-12, Supp. Vol. III: Exhibits 13-18, Supp. Vol. IV: SEALED Exhibits 19-26, Supp. Vol. V: Exhibits 27-33. [14-6244]
12/29/2014		[10236295] Supplemental record on appeal filed. No. of Volumes: 31 (This supplemental record was docketed in several transactions due to the size). Supp. Vol. VI: SEALED Exhibits 34-46, Supp. Vol. VII: Exhibits

DATE	NO.	PROCEEDINGS
		47-50, Supp. Vol. VIII: Exhibits 51-54, Supp. Vol. IX: SEALED Exhibit 55, Supp. Vol. X Exhibits 56-71. [14-6244]
12/29/2014		[10236308] Supplemental record on appeal filed. No. of Volumes: 31 (This supplemental record was docketed in several transactions due to the size). Supp. Vol. XI: Exhibits 72-74, Supp. Vol. XII: Exhibit 75.1.1, Supp. Vol. XIII: Exhibit 75.1.2, Supp. Vol. XIV: Exhibit 75.1.3, Supp. Vol. XV: Exhibit 75.1.4. [14-6244]
12/29/2014		[10236327] Supplemental record on appeal filed. No. of Volumes: 31 (This supplemental record was docketed in several transactions due to the size). Supp. Vol. XVI: Exhibit 75.2.1, Supp. Vol. XVII: Exhibit 75.2.2, Supp. Vol. XVIII: Exhibit 76.1, Supp. Vol. XIX: Exhibit 76.2, Supp. Vol. XX: Exhibit 76.3. [14-6244]
12/29/2014		[10236353] Supplemental record on appeal filed. No. of Volumes: 31 (This supplemental record was docketed in several transactions due to the size). Supp. Vol. XXI: Exhibit 76.4, Supp. Vol. XXII: Exhibit 77,

DATE	NO.	PROCEEDINGS
		Supp. Vol. XXIII: SEALED Exhibits 78-79, Supp. Vol. XXIV Exhibits 80-88. [14-6244]
12/29/2014		[10236361] Supplemental record on appeal filed. No. of Volumes: 31 (This supplemental record was docketed in several transactions due to the size). Supp. Vol. XXV: SEALED Exhibit 93.1.1, Supp. Vol. XXVI: SEALED Exhibit 93.1.2, Supp. Vol. XXVII: SEALED Exhibit 93.1.3, Supp. Vol. XXVIII: SEALED Exhibit 93.2.1, Supp. Vol. XXIX: SEALED Exhibit 93.2.2. [14-6244]
12/29/2014		[10236369] Supplemental record on appeal filed. No. of Volumes: 31 (This supplemental record was docketed in several transactions due to the size). Supp. Vol. XXX: Dft. Exhibits 34-35, Supp. Vol. XXXI: SEALED Exhibits 94-95. [14-6244]
	* * * *	
12/31/2014		[10236906] Appellant/Petitioner's brief filed by Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner. 7 paper copies to be provided to the court. Served on 12/31/2014

DATE	NO.	PROCEEDINGS
		by email. Oral argument requested? Yes. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] [Edited 12/31/2014 by AS. Counsel indavertently submitted brief without attachments. They submitted them by email and were attached to the brief in order to cure deficiency] PPG
01/06/2015		[10237438] Motion filed by Appellees Steve Burrage, Kevin J. Gross, Gene Haynes, Frazier Henke, Linda K. Neal, Robert C. Patton, Michael W. Roach, Anita K. Trammell and Earnest D. Ware to supplement the record on appeal. Served on: 01/06/2015. Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] -[Edited 01/06/2015 by AS to attach sealed documents to motion submitted by counsel] JDH
01/06/2015		[10237631] Order filed by Clerk of the Court granting Appellees' motion to supplement the record on appeal. Materials attached to appellees' motion will be added

DATE	NO.	PROCEEDINGS
		as a supplemental record volumes. Served on 01/06/2015. [14-6244]
01/06/2015		[10237657] Supplemental record on appeal filed. No. of Volumes: 33 (This supplemental record on was docketed in several transactions due to the size) Supp. Vol. XXXII: Exhibits 33 and 41; Supp. Vol. XXXIII: Sealed Exhibits 16-24. [14-6244]
01/06/2015		[10237782] Appellee's brief filed by Steve Burrage, Kevin J. Gross, Gene Haynes, Frazier Henke, Linda K. Neal, Robert C. Patton, Michael W. Roach, Anita K. Trammell and Earnest D. Ware. 7 paper copies to be provided to the court. Served on: 01/06/2015. Manner of service: email. Oral argument requested? No. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] [Edited 01/06/2015 by AS to upload substituted brief showing oral argument statement on front cover of brief] JDH
01/08/2015		[10238217] Motion filed by Appellants Benjamin R. Cole, Richard E. Glossip, John M.

DATE	NO.	PROCEEDINGS
		Grant and Charles F. Warner to supplement the record on appeal. Served on: 01/08/2015. Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] -[Edited 01/08/2015 by AS to add transcripts counsel wishes to add as a supplemental record on appeal] PPG
01/08/2015		[10238498] Sealed motion filed by Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner for stay of Executions Pending Appeal. Served on: 01/08/2015 Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] PPG
01/08/2015		[10238499] Appellant/Petitioner's reply brief filed by Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner. 7 paper copies to be provided to the court. Served on 01/08/2015. Manner of Service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] PPG

DATE NO.	PROCEEDINGS
01/09/2015	[10238582] Sealed motion filed by Benjamin R. Cole, Richard E. Glossip, John M. Grant and Charles F. Warner for stay of Executions Pending Appeal. Served on: 01/09/2015 Manner of service: email. This pleading complies with all required (privacy, paper copy and virus) certifications: Yes. [14-6244] PPG
01/09/2015	[10238811] Order filed by Clerk of the Court granting Appellants' motion to supplement the record on appeal with the trial transcript of the district court hearing dated December 15, 2014. Served on 01/09/2015. [14-6244]
01/09/2015	[10238815] Supplemental record on appeal filed. No. of Volumes: 34. Supp. Vol XXXIV Transcripts of District Court Hearing Dated December 15, 2014. [14-6244]
01/12/2015	[10238935] Order filed by Judge Briscoe appointing the Offices of the Federal Public Defenders for the Western District of Oklahoma and the District of Arizona to represent appellants. Served on. [14-6244]

DATE	NO.	PROCEEDINGS
01/12/2015		[10238940] Affirmed; Terminated on the merits after submissions without oral hearing; Written, signed, published;. Judges Briscoe (author), Gorsuch and Matheson. Mandate to issue 2/3/2015. [14-6244] Plaintiffs' emergency motion for stay of execution pending appeal is denied. -[Edited 01/12/2015 by AS to correct typo in docket text, reformat cover letter and correct citation on page 2 of opinion]
01/12/2015		[10238944] Judgment for opinion filed. [14-6244]
01/12/2015		[10239057] Minute order filed -. (Text Only - No Attachment) Corrected Opinion filed. Citation on page 2 of opinion now shows 28 U.S.C. § 1292(a)(1) [14-6244]
01/15/2015		[10240237] Petition for writ of certiorari filed by Charles F. Warner on 01/13/2015. Supreme Court Number 14-7955. [14-6244]
01/15/2015		[10240349] Order from the US Supreme Court denying application for stay of execution of Charles Warner. Original. Served on 01/15/2015. Manner of Service: email. [14-6244]

DATE NO.	PROCEEDINGS
01/22/2015	[10241955] Minute order filed minor typographical errors in the opinion were fixed. (Text Only - No Attachment) [14-6244]
01/23/2015	[10242588] Order list from the US Supreme Court showing the grant of Certiorari dated January 23, 2015. Original only. Served on 01/23/2015. Manner of Service: email. [14-6244]
01/26/2015	[10242684] Supreme court order dated 01/23/2015 granting certiorari filed. [14-6244]
01/28/2015	[10243486] Order from the US Supreme Court granting a stay of execution for Messrs. Glossip, Grant and Cole pending final disposition of Supreme Court Case 14-7955, Glossip, et al. v. Gross, et al filed by. Original. Served on 01/28/2015. Manner of Service: email. [14-6244]
02/03/2015	[10245151] Order filed by Judges Briscoe, Gorsuch and Matheson staying execution of the mandate pending United States Supreme Court's Final Disposition. Served on 02/03/2015. [14-6244]

UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

CHARLES F. WARNER, *ET AL.*,

Plaintiffs,

v.

KEVIN J. GROSS, *ET AL.*,

Defendants.

No. CIV-14-665-F

MOTION IN LIMINE AND BRIEF IN SUPPORT

COME NOW Plaintiffs Warner, Glossip, Grant, and Cole and move to limit the testimony of Defendants' expert R. Lee Evans to his area of expertise. In support of this motion, Plaintiffs state as follows:

1. Defendants' Expert Report and attachments identify R. Lee Evans as having a Ph.D. in pharmacy and being a board certified psychiatric pharmacist. (Letter to J. Hadden from R. Evans dated Dec. 2, 2014, Defs' Bates No. 6368-6372.)

2. Dr. Evans was asked by Defendants to address the "pharmacological effects of the drugs used in the execution protocol for the State of Oklahoma." (Evans letter at 6368.) Plaintiffs do not challenge Dr. Evans' qualifications to address the pharmacological effects of drugs.

3. Dr. Evans' proposed testimony and opinion, however, extend beyond the pharmacological effects of drugs and beyond knowledge acquired in his special

discipline. Dr. Evans does not have sufficient specialized knowledge to to express any opinion or conclusion about movements of "brain dead" patients. (*See* Evans Letter at 6372)(opining on "involuntary movements"). He is unqualified to postulate regarding an offenders' movements or suggest causes for such movements. Dr. Evans has no training, education, experience or skill to reach an opinion regarding this subject. He is not qualified to offer such opinions and his unqualified opinions offer no assistance to this Court. *Kumho Tire Col, Ltd. v. Carmichael*, 526 U.S. 137 (1999); *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993).

4. Dr. Evans' proposed testimony and opinion on "involuntary movements" should also be excluded because it does not satisfy the demands of Rule 702 of the Federal Rules of Evidence. His proposed testimony and opinions are not "based upon sufficient facts or data," are not "the product of reliable principles and methods," and he has not reliably applied scientific principles and methods to the facts of this case.

5. Dr. Evans' testimony and opinion regarding "involuntary movements" is based upon the reasoning from a brief observation note published in The American Journal of Medicine from a study by Argentinian physicians regarding spontaneous and reflex movements in 107 brain dead patients.

6. Dr. Evans offers no source for his statement that "[s]ome involuntary motor movements may be observed during normal anesthesia and have been observed during execution by injection." (Evans' letter at 6372.)

When an expert's testimony and opinions are challenged under *Daubert* and *Kumho*, as they are

here, it is the proponent of the testimony who bears the burden to establish the admissibility of the pertinent evidence by a preponderance of the evidence. *Ralston v. Smith & Nephew Richards, Inc.*, 275 F.3d 965, 970, n. 4 (10th Cir. 2001). See Fed. R. Evid 702, Advisory Committee notes. This Court's gatekeeper obligations under *Daubert* and Rule 702 are set forth extensively in *Graves v. Mazda Motor Corp.*, 675 F. Supp 2d 1082, 1090-1095 (W.D. Okla. 2009), *aff'd*, 405 Fed. Appx. 296 (2010).

Wherefore, Plaintiffs request that this Court limit the testimony of Defendants' expert to evidence within his expertise and further prevent the admission of unreliable evidence that goes beyond Dr. Evans' knowledge, skill, and education.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 15th day of December, 2014, I electronically transmitted the foregoing document to the Clerk of Court using the ECF System for filing and transmittal of a Notice of Electronic Filing to the following ECF registrants:

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IN THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF OKLAHOMA

CHARLES F. WARNER, *et al.*,

Plaintiffs,

vs.

KEVIN J. GROSS, *et al.*,

Defendant.

Case No. CIV-14-0665-F

ORDER DENYING MOTION FOR PRELIMINARY INJUNCTION

On November 10, 2014, a motion for preliminary injunction was filed, doc. no. 92, by plaintiffs Charles Frederick Warner, Richard Eugene Glossip, John Marion Grant and Benjamin Robert Cole. The motion came on for evidentiary hearing on December 17, 18 and 19, 2014.

For the reasons stated at length on the record, pursuant to Rule 52(a)(1), Fed.R.Civ.P., the court concludes that movants have failed to establish any of the prerequisites to a grant of preliminary injunctive relief. Specifically, the court concludes that the movants have failed to establish a probability of success on the merits of any of the five claims they assert for preliminary injunction purposes, even under the relaxed standard articulated in *Kikumura v. Hurley*, 242 F.3d 950, 955 (10th Cir. 2001). The court further concludes that movants have failed to demonstrate that, absent a preliminary injunction,

they would suffer any non-speculative irreparable harm. The court further concludes that the balance of equities does not tip in movants' favor. Finally, the court concludes that entry of a preliminary injunction would not be in the public interest.

The court accordingly concludes that the motion of Charles Frederick Warner, Richard Eugene Glossip, John Marion Grant and Benjamin Robert Cole for preliminary injunction is without merit. The motion is accordingly DENIED.

Dated December 22, 2014.

/s/ Stephen P. Friot
STEPHEN P. FRIOT
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-665-F

CHARLES F. WARNER, *et al.*,

Plaintiffs,

vs.

KEVIN J. GROSS, *et al.*,

Defendants.

TRANSCRIPT OF COURT'S RULING BEFORE
THE HONORABLE STEPHEN P. FRIOT
UNITED STATES DISTRICT JUDGE
DECEMBER 22, 2014
3:00 P.M.

[2] APPEARANCES

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[3] (PROCEEDINGS HAD DECEMBER 22, 2014.)

THE COURT: Good afternoon. We're here in Civil 14-665, Charles Warner and others v. Kevin Gross and others, for the Court's ruling on the motion of four plaintiffs for preliminary injunction. Counsel will please give your appearances.

MS. GHEZZI: Patti Ghezzi for the plaintiffs that are represented by the Federal Public Defender's Office in the Western District.

MS. HENRICKSEN: Lanita Henricksen for Andrew, Warner, Hancock, Jackson, and Glossip.

MR. AUTRY: David Autry for James Coddington, Your Honor.

THE COURT: We have Arizona counsel present by telephone?

MS. KONRAD: Yes. Robin Konrad and Dale Baich for Plaintiff Tremane Wood.

MR. HADDEN: John Hadden for state defendants, Your Honor.

MR. STEWART: Aaron Stewart for state defendants, Your Honor.

THE COURT: I'll now make my findings of fact and conclusions of law with respect to the preliminary injunction which has be[illegible]—motion for preliminary injunction which has been filed by Plaintiffs Charles Warner, Richard Glossip, John [4] Grant, and Benjamin Cole.

The hearing on these plaintiffs' motion for preliminary injunction was held on December 17, 18, and 19, 2014. The plaintiffs were ably represented by Dale A. Baich, Robin C. Konrad, Patti P. Ghezzi, and Randy A. Bauman. The defendants were ably represented by John D. Hadden, Aaron J. Stewart, and Jeb E. Joseph. Over three full days of hearings, generating 694 pages of transcript, the plaintiffs called 14 witnesses, including several Oklahoma Department of Corrections employees, and the defendants called three witnesses.

My scheduling of the hearing on the motion for preliminary injunction, as well as my scheduling of the preparatory steps leading to the hearing was driven by the fact that these four movants are scheduled for execution beginning in the case of Charles Warner on January 15, 2015. That necessitated a rather compressed schedule. Even though the schedule was compressed, there were certain essential steps that, although unfolding on a tight time schedule, certainly could not be eliminated. As an example, it was my conclusion that the plaintiffs ought to have the benefit of discovery as thorough and searching as was possible under the circumstances. And I believe that plaintiffs have indeed had the benefit of thorough discovery.

Plaintiffs' discovery began, at least in terms of substantial discovery, with the production of thousands of pages of documents that were either turned over to the [5] Department of Public Safety or generated by the Department of Public Safety in the investigation that was conducted by that agency following the Lockett execution. That included thousands of pages of interview transcripts as well as numerous original source documents.

And before I go any further, I will say again that I applaud the diligence and professionalism of counsel on both sides. For the reasons I have described, among others, this has been, to put it mildly, a very demanding case, especially in the run-up to the three-day hearing last week. Although there were some instances in which I had to referee discovery disputes on fairly short notice, I can say without hesitation that preparation for the preliminary injunction hearing proceeded with less rancor than there would have been if counsel on both sides had not made every effort as true professionals to bring the matter to this stage with a hard focus on the merits and with minimal diversions unrelated to the merits.

I am making my findings of fact and conclusions of law in this setting, on the record, as permitted by Rule 52(a). As I said at the end of the day last Friday, I could take another five or six working days to turn out a polished 35- or 40-page order, but I am certain that the parties and their counsel would rather have those five or six days back so that they can prepare for the next stage of this litigation, which will [6] necessarily unfold between now and January 15, 2015. I will assure all concerned, however, that even though I am ruling from the bench rather than taking another five or six days to produce a formal written order, the

findings and conclusions that I'm about to express are made with all of the thought process that would ultimately go into a formal order.

Many of the matters that I'm about to address involve mixed issues of fact and law. For that reason, it is in some ways a bit artificial to speak in terms of findings of fact separately from conclusions of law. I will separate the two as much as I reasonably can. However, I am confident that the parties, as well a reviewing court, will be able to discern the difference between my factual findings and my legal conclusions. In any event, of course, to the extent that I express a legal conclusion as if it were a matter of fact, it should be regarded as a legal conclusion and vice versa.

My exceedingly capable reporter is prepared to produce a transcript of my ruling in very short order. For ease of reference by the parties and by a reviewing court, the reporter has advised me that it would be permissible for me to insert headings into the transcript before the transcript is filed. I think that would be helpful to all concerned and I will do that before the transcript is filed. I assure you, however, that because of the very nature of a ruling from the bench, I will not make any change of any kind in the record of my ruling as [7] taken by the reporter.

I'll now turn to the factual history of this matter.

FACTUAL HISTORY

Clayton Derrell Lockett, having been convicted of first degree murder and sentenced to death, was scheduled for execution at the Oklahoma State Penitentiary on April 29, 2014. The execution took place as scheduled and it achieved the intended result, the death of Clayton Lockett, but the execution was

ineptly performed in some ways, as I will discuss later in these findings.

As a result of the extraordinary events surrounding the Clayton Lockett execution, Governor Mary Fallin issued Executive Order 2014-11 on April 30, 2014, which mandated an independent investigation of the events leading up to and during the execution of Clayton Lockett. The Governor's Executive Order appointed Michael Thompson, the Secretary of Safety and Security and the Commissioner of the Department of Public Safety to lead the independent investigation process.

The Department of Public Safety investigation culminated in the issuance of a report entitled "The Execution of Clayton D. Lockett," Case Number 14-0189SI, by the Oklahoma Department of Public Safety. On September 16, 2014, that report was filed in this action as Docket Entry Number 49-1.

The DPS report contains a wealth of information, much of it favorable to the plaintiffs. The plaintiffs have asserted [8] that for their purposes there are some relevant facts that are not included in the DPS report. That is correct. An encyclopedic report on the Lockett execution would probably have run to 3- or 400 pages rather than 29 pages. But the DPS report, which resulted from a thorough investigation that was conducted with noticeable professional integrity by Captain Jason Holt, under the supervision of Commissioner of Public Safety Michael Thompson, certainly provided plaintiffs with a good starting point. By the time Captain Holt left the witness stand last Thursday, no one in this courtroom could have doubted the seriousness with which he took his assignment to lead the DPS investigation.

Meanwhile, this action was filed on June 25, 2014. As indicated by the allegations on pages 6 to 9 of the original complaint in this case, Docket Entry Number 1, the plaintiffs' original complaint in this action centered substantially on the events surrounding the execution of Clayton Lockett. The same is true of the amended complaint, Docket Entry Number 75, filed on October 31, 2014.

The amended complaint also focuses on the revised execution protocol adopted by the Oklahoma Department of Corrections, DOC Policy OP-040301, with an effective date of September 30, 2014. I will discuss that revised protocol as relevant to the issues now before the Court later in my findings.

[9] THESE FOUR PLAINTIFFS

Although the plaintiffs in this action include all or nearly all of the death row inmates in the state of Oklahoma, the matter now before the Court is the motion for preliminary injunction which was filed by four of those plaintiffs; namely, Charles Frederick Warner, Richard Eugene Glossip, John Marion Grant, and Benjamin Robert Cole. The four plaintiffs who have filed this motion for preliminary injunction have been scheduled for execution, respectively, on January 15, January 29, February 19, and March 5, 2015.

As recounted by the Oklahoma Court of Criminal Appeals at 144 P.3d 838, Charles Warner raped and murdered an 11-month-old baby girl on August 22, 1997, an assault which resulted in, among other injuries, two skull fractures including a depressed fracture and two fractures of the baby girl's left jaw.

As recounted by the Oklahoma Court of Criminal Appeals, 157 P.3d 143, on January 7, 1997, Richard Glossip hired Justin Sneed to kill Barry Van Treese,

the employer of Glossip and Sneed, which Sneed proceeded to do by bludgeoning Van Treese to death with a baseball bat.

As recounted by the Oklahoma Court of Appeals, 95 P.3d 178, on November 13, 1988, John Grant, then an inmate at the Connor Correctional Center in Hominy, Oklahoma, murdered Gay Carter, a food service supervisor at the Connor Correctional Center, by stabbing her 16 times with a shank.

[10] As recounted by the Oklahoma Court of Criminal Appeals, 164 P.3d 1089, on December 20, 2002, Benjamin Cole murdered his nine-month-old daughter, Brianna Cole, by snapping her spine in half and inflicting other fatal injuries because she would not stop crying.

All four of the moving plaintiffs have reached the end of their trial, direct review and collateral review process, which includes, in the case of Messrs. Warner and Glossip, two trials, two first degree murder convictions, and two sentences of death.

I will now address the facts surrounding the Lockett execution.

THE LOCKETT EXECUTION

Although a number of preliminary steps took place earlier in the day on April 29, 2014, and even before that day, the final sequence of events leading to the execution of Clayton Lockett began at approximately 5:22 p.m. on April 29 when Lockett was placed onto the execution table and strapped down. Earlier in the day, Lockett had twice refused visits from his attorneys. He had also cut himself twice on April 29 at "the bend of the elbow," as described by Warden Trammell. That is as page 225 of the transcript.

The execution of Clayton Lockett was the first Oklahoma execution using midazolam. The protocol called for the administration of 100 milligrams of midazolam, 40 milligrams of [11] vecuronium bromide, and 200 milliequivalents of potassium chloride. Midazolam had been added to the protocol approximately two weeks before the Lockett execution after it was determined that pentobarbital would not be available for the Lockett execution.

On April 29, before the blinds between the execution chamber and the reviewing rooms were raised, the execution team had worked for nearly an hour trying to establish intravenous access to Lockett's cardiovascular system. Postmortem examination revealed at least a dozen needle puncture marks on Lockett's body indicating at least that many attempts to establish IV access.

The first member of the execution team who was involved in securing intravenous access to Lockett's cardiovascular system was an emergency medical technician licensed as a paramedic. The paramedic attempted, without success, to establish IV access in the typical location in the crook of Lockett's left arm. Three attempts to establish IV access at that location were unsuccessful.

Next a physician member of the execution team attempted to establish IV access through Lockett's left jugular vein. Although it appeared momentarily that this attempt had been successful, that success was short-lived. At the same time, the paramedic attempted to establish IV access by way of Lockett's right arm. Three attempts to do so were [12] unsuccessful. After those unsuccessful attempts, the physician sought unsuccessfully to establish IV access through Lockett's left subclavian vein and the

paramedic attempted to establish IV access in two locations on Lockett's right foot.

The physician next attempted to establish IV access by way of Lockett's right femoral vein. The physician and the paramedic concluded that this attempt had been successful. To facilitate right femoral IV access, the physician asked for a longer catheter so that they could attempt to establish IV access through Lockett's femoral vein.

A one-and-a-quarter-inch 14-gauge angiocatheter was used for this purpose. The one-and-a-quarter-inch needle was inserted and was "positional," meaning the patency of the IV flow was dependent upon relatively precise positioning of the catheter. This one-and-one-quarter-inch catheter was taped in place. The use of the one-and-a-quarter-inch catheter was clearly inappropriate, a failure that is made all the more inexplicable by the fact that a central line IV kit was available.

After the physician and the paramedic concluded that femoral IV access had been established, Warden Trammell covered Lockett's body with a sheet. For the purpose of preserving Lockett's privacy, his genital area was covered. This was an improvident decision. From that point until it appeared that there may be a problem with intravenous flow, Lockett's genital [13] area remained covered and the IV access point could not be observed.

There was approximately a 23-minute delay in the beginning of the execution. This delay was evidently due to the difficulties in establishing acceptable IV access. The blinds were raised at approximately 6:23 p.m. After the blinds were raised, Warden Trammell

read the death warrant and Lockett was asked whether he had any last words. He had none.

The execution team began to push the midazolam into the IV manifold. Administration of the midazolam was followed by administration of the vecuronium bromide and potassium chloride, both by way of the right femoral IV access point. Confirmation of continuous IV flow was, to put it mildly, hampered by the fact that the execution team put a hemostat on the IV line and then they covered the IV injection access point with a sheet with the result that, in the words of Captain Holt at page 408 of the transcript, they had "covered the one and stopped the other," which made it impossible to confirm that the IV flow continued or even that it could continue.

At approximately 6:30, the physician performed a consciousness check and determined that Lockett was conscious. At approximately 6:33, Lockett was determined to be unconscious and the vecuronium bromide was pushed, followed by a saline flush and the potassium chloride. Shortly after that, Lockett began to move. He raised his head and was heard to say, "man" [14] or "oh, man." By the account of Edith Shoals, which I find to be credible, Lockett said, "This shit is fucking with my mind." That is at page 204 of the transcript. Lockett was heard to mumble "something is wrong," and he moved his shoulders and head forward. By the account of Jeanetta Boyd, which was also credible, Lockett was heard to say, "The drugs aren't working." That is at page 182 of the transcript. After these movements and verbalizations, the blinds were closed at the direction of Warden Trammell.

The physician recognized that there was a problem. The physician lifted the sheet and recognized that the

IV had infiltrated, meaning that the IV fluid had leaked into the tissue surrounding the IV access point. The physician noted an area of swelling under Lockett's skin. It was smaller than a tennis ball but larger than a golf ball. It is evident from the autopsy photographs and from the testimony that a bulge of that size, unmistakably indicating a serious infiltration problem, could have and should have been noticed at a significantly earlier stage of the execution process.

Vecuronium bromide is a potent paralytic agent. The intravenous administration of a massive dose of vecuronium bromide, as was called for by the lethal injection protocol that governed Lockett's execution, would have resulted in complete paralysis. Lockett would have been unable to breathe, speak, or raise his head. During this phase of his execution, [15] Lockett was surely experiencing all of the mental pain that is inevitable in the execution process as well as serious physical discomfort if not serious physical pain.

Postmortem toxicology confirmed the presence of midazolam as well as vecuronium and potassium in Lockett's femoral blood at 45 milliequivalents for the potassium and 460 nanograms per milliliter for the vecuronium. The vecuronium bromide was pushed after the midazolam but before the potassium chloride and the vecuronium obviously did not immediately have its intended paralytic effect. Not all of the potassium chloride was pushed, but the potassium chloride was behind the vecuronium bromide and the vecuronium bromide clearly did not flow into Lockett's cardiovascular system in the manner contemplated by the lethal injection protocol. Consequently, it is not possible to determine the extent to which Lockett

suffered the searing pain that would result from an injection of potassium chloride into a sensate person.

Although I cannot and do not find that Lockett was not in pain during this part of the execution process, I do note that during the time that Lockett moved, vocalized, and raised his head and shoulders, of all of the verbalizations attributed to Lockett, at least two of which were complete sentences, the most specific, emphatic, and intelligible statement was, "This shit is fucking with my mind." Which may or may not be a statement that one would have expected Lockett to make if he [16] was feeling the searing pain that he certainly would have felt if he had been conscious while any substantial amount of sodium chloride was being delivered to his tissues.

By all accounts, potassium chloride will cause a sensate individual to feel serious pain. It is clear that patent IV flow of potassium chloride into the cardiovascular system of Clayton Lockett, while conscious and sensate, would have had the extremely painful effect that has been described because patent IV flow would have delivered the substance throughout his body to the most sensitive receptors. What is not clear from the evidence is the extent to which that, in fact, occurred.

After the swelling in Lockett's groin was noted, the execution process was halted and the blinds were lowered at about 6:42 p.m., approximately 20 minutes after the midazolam was administered. Administration of the second syringe of potassium chloride was stopped. The paramedic assessed the situation and concluded that the IV catheter was no longer penetrating the vein. The physician attempted IV insertion into the left femoral vein. The needle

penetrated the femoral artery rather than the femoral vein. No left femoral IV access was established.

At this juncture, Director Patton asked Warden Trammell two questions. First, do you have another viable vein? And, second, do you have any more chemicals to push? Warden [17] Trammell told Director Patton that there was no viable vein. After that, the physician told the warden and the warden relayed to Director Patton that not enough drugs had entered Lockett's body to cause death.

The autopsy of Lockett indicated that there were concentrations of midazolam in the tissue near the insertion site in Lockett's right groin area. This indicated that the drugs were not flowing intravenously into Lockett's cardiovascular system and that this problem had existed as early as the stage at which the midazolam was being administered.

At 6:56 p.m., after two conversations with Governor Fallin's counsel, Director Patton terminated the execution process, although the administration of the drugs had been stopped at about 14 minutes before that. Witnesses were escorted out of the viewing room. At 7:06 p.m., Lockett was pronounced dead. He died as a result of the lethal injection. The drugs that were intended to be lethal had their intended effect.

As to the opportunity for the witnesses to see what was happening, the blinds between the execution chamber and the viewing rooms were raised and lowered once during Lockett's execution. The individuals who viewed the execution room from the viewing room had been seated in the viewing room by 6 p.m. At approximately 6:23 p.m., after Director Patton received [18] approval from the governor's office to proceed with the execution, the blinds were

raised. The blinds were still up when the physician inspected the femoral IV insertion site and concluded that there was a problem with IV access. At 6:42 p.m., when the administration of the second syringe of potassium chloride was stopped, the blinds were lowered. The blinds remained down from that point until Lockett was pronounced dead.

The autopsy disclosed wounds consistent with the IV access attempts that I have described. The autopsy also indicated that both midazolam and vecuronium bromide were found in the psoas muscle indicating that those chemicals had been distributed throughout Lockett's body. The concentration of midazolam found in Lockett's blood was greater than the concentration required to render an average person unconscious.

I will now make my findings with respect to the revision of the lethal injection protocol and Department of Corrections practice under that protocol.

THE REVISION TO THE PROTOCOL AND DOC PRACTICE UNDER THAT PROTOCOL

As I have noted, the DOC adopted a new protocol entitled "Execution of Offenders Sentenced to Death" with an effective date of September 30, 2014. Including attachments, the revised protocol is 55 pages long.

I do not consider it necessary to go into a detailed [19] side-by-side comparison of the revised protocol versus the previous protocol, but it is safe to say that with respect to the matters that are most relevant here, specifically the procedures for establishing IV access to the offender's cardiovascular system, the procedure for administering the chemicals, and the procedures for dealing with mishaps or unexpected

contingencies, the new protocol is noticeably more detailed. The revised protocol also includes detailed provisions with respect to training and pre-execution preparation of the members of the execution team.

The new protocol is in evidence as Plaintiffs' Exhibit 68. A copy of the new protocol is also in the record at Docket Entry Number 55-1 filed on October 1, 2014.

The new protocol provides for several teams to participate in and complete the execution process, including the Intravenous Team, as indicated on page 7. The IV Team consists of a team leader and one or more physicians, physician assistants, nurses, emergency medical technicians, paramedics, or a military corpsman, or other certified or licensed personnel, including those trained in the U.S. Military. The team leader and members shall be "currently certified or licensed within the United States."

Practitioners in some of those categories, such as physicians, must be licensed and others, like military corpsman, are credentialed by certification. The new protocol [20] provides that a central femoral venous line shall not be used unless the person placing the line is currently certified or licensed within the United States to place a central femoral line. That is on page 27. That is not a particularly meaningful requirement because there is no licensing or certification specific to that procedure.

The team leader and members are selected by the director of the DOC on the basis, among other things, of the proposed team member's qualifications, training, experience, and professional licenses or certification, as indicated on page 7.

I'll now address training under the revised protocol.

TRAINING UNDER THE REVISED PROTOCOL

Warden Anita Trammell acknowledged that after the Lockett execution she realized that the training of the execution team had been, in point of time, "up to bringing the offender into the execution chamber." She testified that "the training should have gone beyond that." I agree with that comment. That is at page 158 of the transcript. The new protocol does call for significantly more training.

For execution team members, the new protocol requires "ten training scenarios within the 12 months preceding the scheduled execution." That is on pages 9 and 10. The training section of the protocol provides for "multiple training scenarios," including but not limited to contingency plans for issues with execution equipment or supplies, issues with offender IV [21] access, including alternate IV access sites, issues if the offender is not rendered unconscious after administration of execution chemicals, and unanticipated medical or other issues concerning the offender or an execution team member, all as covered on page 10.

Two days prior to the day of execution, the division manager is required to schedule and conduct "on-site scenario training sessions, modifying practices as warranted," as indicated on page 22. The training section of the revised protocol also requires that the IV Team members "shall participate in at least one training session with multiple scenarios within one day prior to the scheduled execution," as indicated on page 10. The H-Unit Section Chief is required to be trained in determining whether there is a problem with IV flow.

This fall, the execution team has been training one day a week for five or six hours in each instance. The

director is included in these training sessions. They train for a minimum of six scenarios each time and sometimes address seven or eight scenarios. The training scenarios include, for instance, situations in which there is a problem with the IV manifold and drills involving access to the femoral vein.

In addition to the training sessions that have been conducted, a training session will be held with the IV Team within 24 hours before the next execution in which the IV Team [22] will address a scenario in which the inmate regains consciousness after having been pronounced unconscious.

Thirty-five days prior to the day of execution, the protocol requires that the offender's medical condition "be assessed in order to identify any necessary accommodations or contingencies that may arise from the offender's medical condition or history," as indicated on page 16. This includes examination for "concerns for establishing or maintaining IV lines," as indicated on page 17.

The offender's telephone privileges are terminated at 9 p.m. on the day prior to the day of execution, except for calls from the offender's attorney of record and others as approved by the division manager. Likewise, visitation is terminated at 9 p.m. on the day before the day of execution, except that two hours of in-person visitation with up to two attorneys of record is permitted as long as that visitation ends two hours prior to the scheduled execution or earlier, if necessary, to begin preparing the offender for the execution, as indicated on page 22.

The revised protocol requires that an electrocardiograph and a backup electrocardiograph be on site available for use during the execution.

The execution team must prepare a complete set of the required chemicals. In addition, "An additional complete set of the necessary chemicals shall be obtained and kept available [23] in the chemical room," as indicated on page 38.

As is set forth on pages 39 through 41 of the revised protocol, the new protocol gives the director four alternatives with respect to the combination of drugs to be used in the lethal injection process. These alternatives are set forth in Chart A, Chart B, Chart C, and Chart D.

Chart A calls for the administration of 5,000 milligrams of pentobarbital in a one-drug procedure. Chart B provides for the administration of 5,000 milligrams of sodium pentothal, again, in a one-drug procedure. Chart C provides for the administration of 500 milligrams of midazolam and 500 milligrams of hydromorphone. Hydromorphone is a narcotic analgesic. Finally, Chart D provides for the administration of 500 milligrams of midazolam, 100 milligrams of vecuronium bromide, and 240 milliequivalents of potassium chloride. Rocuronium bromide will apparently be used in the upcoming executions, but it is not materially different from vecuronium bromide, aside from what Dr. Katz referred to as "a dosing change," which apparently is not in controversy.

The protocol provides that the director shall have the sole discretion to determine which chemicals will be used for the scheduled execution. This decision is required to be provided to the offender in writing ten calendar days before the scheduled execution date, as indicated on page 41. If it is necessary to use a compounded drug, the compounded drug [24] "shall be obtained from a certified or licensed compounding

pharmacist or compounding pharmacy in good standing with their licensing board." The protocol requires a qualitative analysis of the compounded drug to be performed no more than 30 days before the execution date. The protocol also requires that the decision to use compounded drugs be provided to the offender in writing not less than ten calendar days before the scheduled execution, as indicated on page 41.

The new protocol provides for the insertion of a primary IV catheter and a backup IV catheter. The primary line is referred to as the "A line." The secondary line is referred to as the "B line." IV access is established at two points, with the A line and the B line. If all goes as planned, the drugs would be entirely injected through the A line. If there is a problem with the A line or with IV access through the A line, then the B line is a backup. The complete second set of execution drugs is for use in the B line or otherwise, if need be. The preferred site for IV access is the "arm veins near the joint between the upper and lower arm," as indicated on page 26. If the IV Team is unable to establish an IV at a preferred site, the IV Team members are authorized to establish an IV at an alternative site, including a central femoral venous line. The protocol states that the IV Team shall be allowed as much time as necessary to establish viable IV sites, but that after one hour of unsuccessful IV attempts, the [25] director must contact the governor or the governor's designee to advise of the status and "potentially request a postponement of the execution," as indicated at pages 26 and 27.

After insertion of the IV needle, the IV Team is required to test the viability of the IV site with a low-pressure saline drip through the IV tubing. If

necessary, a Heparin lock may be attached to the IV needle as an alternative to the saline drip as indicated on page 27.

The protocol contains detailed provisions for monitoring the condition of the offender during the execution process, including a requirement that a microphone be affixed to the offender's shirt to enable the execution team "to hear any utterances or noises made by the offender throughout the procedure," as indicated on page 43.

For the purpose of monitoring the offender's cardiac status, the protocol requires that execution team members "attach the leads from the electrocardiograph to the offender's chest once the offender is secured. The IV Team leader shall confirm that the electrocardiograph is functioning properly. A backup electrocardiograph shall be on site and readily available if necessary. Prior to and on the day of the execution, both electrocardiograph instruments shall be checked to confirm that they are functioning properly," as indicated on page 43.

Finally, on the subject of monitoring, the protocol [26] requires that the IV Team leader "monitor the offender's level of consciousness and electrocardiograph readings utilizing direct observation, audio equipment, camera and monitor, as well as any other medically approved methods deemed necessary by the IV Team leader. The IV Team leader shall be responsible for monitoring the offender's level of consciousness," as indicated on page 43.

Although the presence of a physician during the execution process is not required under the revised protocol, a physician has been selected as the IV Team leader for the executions of the four plaintiffs who seek

a preliminary injunction. The second member of the IV Team will be a paramedic. Warden Trammell testified that the consciousness check will be performed by the physician.

The protocol requires that the IV catheter remain visible to the H-Unit Section Team Chief throughout the execution procedure and that the H-Unit Section Team Chief remain in the room with the offender "in a position sufficient to clearly observe the offender and the primary and backup IV sites for any potential problems." The Section Team Chief is required to immediately notify the IV Team leader and the director if any problem is observed, as indicated at page 44.

The H-Unit Section Team Chief is required to observe the offender during the injection process "to look for signs of swelling or infiltration at the IV site, blood in the catheter [27] and leakage from the lines, and other unusual signs or symptoms," as indicated on page 27. For that reason, it falls to the H-Unit Section Team Chief to determine whether it is necessary to use an alternative IV site. When an alternative IV site is used, the team members who administer the chemicals are required to administer a full dose of the execution drugs through the alternative site, as indicated on page 27.

To facilitate the level of scrutiny required by the new protocol, the operations room adjacent to the execution chamber now has two video monitors with feeds from two cameras. Both cameras have tilt, turn, and zoom capability. One camera is located near the head of the gurney and the other camera is located near the foot of the gurney. With these cameras, the IV Team members can monitor the point of IV access on the offender's body.

The lapel microphone on the prisoner provides a continuous audio feed into the operations room where most of the participants in the execution process will be during the execution. This microphone comes on at the beginning of the execution and is not turned off until the offender is pronounced dead. There is a separate microphone over the offender's head. This microphone feeds to the viewing room and to the overflow room. This microphone is turned on when the blinds are raised and is turned off after the offender makes his final statement, if he chooses to make one. It is then [28] turned back on for the doctor to announce the results of the consciousness check and immediately turned off. It is then turned on for the announcement of the time of death.

There are three telephones in the operations room: one to maintain contact with the governor's office, one to maintain contact with the Attorney General's Office, and one for the purposes of communications within the Oklahoma State Penitentiary. In addition, there is an intercom between the execution chamber and the operations room.

With respect to the actual administration of the lethal injection chemicals, the new protocol has one procedure for administration of the chemicals specified in Charts A, B, and C and a slightly different procedure for administration of the three-drug sequence specified in Chart D, as indicated at pages 44 to 46.

With respect to all four chemical charts, the IV Team leader is required to enter the room where the offender is located "to physically confirm the offender is unconscious by using all necessary and medically appropriate methods," as indicated on pages 44 and 46.

If there is a delay in losing consciousness, the IV Team is required to inform the director so that the director can determine how to proceed or whether to "start the procedure over at a later time or stop," as indicated on pages 45 and 46. The director has the discretion to instruct the execution team [29] to administer additional doses of the chemical, as indicated, again, on pages 45 and 46.

The execution facility is now equipped with an electrocardiograph machine to monitor the offender's blood pressure, oxygen saturation, and heart activity during the execution process. A backup machine is available in the event there is a problem with the primary machine. The DOC also purchased an ultrasound machine for use, if need be, in locating a deep vein and the stock of surgical supplies has been improved, to include a newly acquired assortment of IV needles. The newly acquired assortment of IV needles was shown to Captain Holt during his recent tour of the execution facility.

The revised protocol calls for an after-action review following the execution. This after-action review includes discussion of "any unique or unusual events," as well as "opportunities for improvement and successful procedures," as indicated on page 31.

I will now make my findings with respect to the unavailability of sodium thiopental and pentobarbital.

UNAVAILABILITY OF SODIUM THIOPENTAL AND PENTOBARBITAL

In paragraph 31 of their amended complaint, plaintiffs proffer sodium thiopental used in a single-drug protocol as their alternative to midazolam, as indicated at Docket Entry Number 75 at page 7. At the

trial last week, pentobarbital was [30] also mentioned several times.

Pentobarbital and sodium thiopental are powerful barbiturates. A massive dose of either of these drugs is lethal. Which is why, as long as they were available, they had a well-established record of successful use in execution by lethal injection, even in drug combinations in which it was not necessary that they have lethal effect.

Pentobarbital and sodium thiopental are both unavailable to the Department of Corrections. Attempts to procure pentobarbital and sodium thiopental have been unsuccessful. It is a judicially noticeable fact that the Lockett execution was preceded by a storm of litigation involving the state and federal district courts as well as the Oklahoma Supreme Court and the Oklahoma Court of Criminal Appeals. The litigation included intense efforts to force the disclosure of the sources of the lethal injection drugs as noted in Lockett v. Evans, 2014 Westlaw 1584517, a decision from the Oklahoma Supreme Court on April 21, 2014. Former Oklahoma Department of Corrections General Counsel Michael Oakley, who retired shortly before the Lockett execution, testified quite believably that "the vendor, because of pressure in the litigation, decided that he didn't want to sell us the pentobarbital any longer." That is at page 296 of the transcript.

Director Patton cannot think of anything he could have done differently in his efforts to get these drugs and the [31] Court credits this testimony. The DOC talked to numerous pharmacies, including compounding pharmacies, in its efforts to procure pentobarbital and sodium thiopental, either commercially manufactured or compounded. These

efforts were not successful. Sodium thiopental and pentobarbital are certainly known alternatives, but it is equally clear that they're not available to the DOC.

I will now analyze the evidence derived from the execution of Clayton Lockett.

ANALYSIS OF EVIDENCE DERIVED FROM THE EXECUTION OF CLAYTON LOCKETT

Dr. Eric D. Katz, a well-qualified emergency physician, had some credible criticisms of the process by which Clayton Lockett was executed. IV access to Clayton Lockett's right femoral vein was established, as I have said, with a one-and-a-quarter-inch 14-gauge angiocatheter. The one-and-a-quarter-inch 14-gauge angiocatheter was not the appropriate equipment to use to accomplish this task. And the use of a catheter of that size substantially increased the risk of serious difficulties in establishing patent intravenous access by way of Clayton Lockett's right femoral vein. It is now common in medical practice to use ultrasound equipment for guidance in establishing intravenous access to the subclavian, internal jugular, or femoral veins.

Dr. Katz also commented with respect to the requirement in [32] the revised protocol that the person placing a central femoral line be "currently certified or licensed within the United States to place a central femoral line." As I have previously mentioned, Dr. Katz pointed out that this specific task is not one for which certification or licensure is available.

Dr. Katz also commented on the medications and techniques which would be necessary to reverse the effect of midazolam, vecuronium, and potassium. Aside from the medications that would be required to

reverse the effects of these drugs, reversal of the effects of vecuronium would require a ventilator and reversal of the effects of a high dose of midazolam would likely require endotracheal intubation, in other words, a breathing tube, with supplies for ventilator assistance. Dr. Katz pointed out that these medications and this equipment necessary for resuscitation of an individual affected by midazolam, vecuronium bromide, and potassium chloride were not available at the time of Clayton Lockett's execution.

Dr. Joseph I. Cohen and Dr. Joni McClain, both well-qualified pathologists, testified with respect to their respective autopsy examinations of the body of Clayton Lockett. Dr. Cohen was called by the plaintiffs and Dr. McClain, who performed the independent autopsy at the Southwestern Institute of Forensic Sciences in Dallas, was called by the defendants. Their observations from their actual examinations did not [33] substantially differ. Dr. Cohen conducted his autopsy in Tulsa on May 14, 2014. Dr. Cohen's autopsy followed the autopsy performed by the Southwestern Institute of Forensic Sciences and the partial examination that was performed by the Oklahoma State Medical Examiner.

Dr. Cohen found numerous punctures and incisions consistent with the several reported attempts to gain IV access at several sites on Clayton Lockett's body, which was consistent with Dr. McClain's findings. Dr. Cohen found, and this is uncontradicted, that Lockett's veins were in good condition and suitable for establishing IV flow of the lethal injection drugs. Dr. Cohen concluded that the manner of death was judicial execution and that the mechanism of death was respiratory depression and cardiac dysrhythmias

directly resulting from the administration of the lethal injection drugs during the execution process.

Commenting on the numerous fresh punctures observable in Clayton Lockett's body, Dr. Cohen stated that his findings, as well as the findings of the Oklahoma state medical examiner and the Dallas medical examiner, support the ineffective application of medical implements. This is accurate.

Dr. Cohen also opined that Clayton Lockett was not dehydrated during the execution and that he likely suffered conscious pain and suffering due to the failed attempts to establish IV access. I have already commented on the issue of [34] whether Lockett experienced pain beyond that inherent in the execution process. As I have discussed, Lockett may well have experienced significant pain, but any such conclusion is laden with an element of speculation.

I will now comment on the nature and characteristics of midazolam and the other drugs at issue.

NATURE AND CHARACTERISTICS OF MIDAZOLAM AND THE OTHER DRUGS AT ISSUE

Plaintiffs called two witnesses who addressed the characteristics of midazolam; namely, Dr. Larry D. Sasich, a pharmacist who holds a Bachelor of Science degree in pharmacy and a doctoral degree in pharmacy; and Dr. David A. Lubarsky, a Professor of Anesthesiology at the University of Miami. Dr. Sasich also commented on the characteristics of vecuronium bromide and potassium chloride.

The defendants called Dr. Lee R. Evans, the holder of a doctoral degree in pharmacy, principally to testify

with respect to the characteristics and effects of midazolam.

Now, several days before the hearing, a Daubert motion was filed with respect to the expert testimony of Dr. Lee Evans. I indicated at the pretrial conference that I would address that—as permitted in a non-jury case, that I would address that after hearing his testimony by way of direct and cross-examination at trial. And I certainly did hear his testimony by way of direct and cross-examination. I reviewed the motion [35] in limine. I made careful note of the extent to which his testimony was challenged in the motion in limine and the subjects on which it was challenged.

The Tenth Circuit has made it very clear that once a Daubert challenge is filed, the Court must make its findings on the record indicating its resolution of the Daubert challenge. And I will now do that at this time.

DAUBERT RULING WITH RESPECT TO THE EXPERT TESTIMONY OF DR. LEE EVANS

On December 15, as I indicated, plaintiffs filed a motion in limine challenging some specific aspects of the proposed expert testimony of Dr. Lee Evans. That motion is at Docket Entry Number 161. For that reason, before making any findings based on the testimony given by the expert witnesses called by the parties, it is necessary to address the Daubert challenge as to Dr. Evans.

The Supreme Court's decisions in Daubert v. Merrell Dow Pharmaceutical, Inc., 509 U.S. 579, and Kumho Tire Company v. Carmichael, 526 U.S. 137, establish a gatekeeper function for trial judges under Rule 702 of the Federal Rules of Evidence. This is commented on at considerable length in the Tenth Circuit's two Goebel decisions, the first one of which is

Goebel v. Denver and Rio Grande Western Railroad Company, 215 F.3d 1083, with the relevant discussion at page 1087, a decision from the Tenth Circuit in 2000. The gatekeeper [36] function "requires the judge to assess the reasoning and methodology underlying the expert's opinion and determine whether it is scientifically valid and applicable to a particular set of facts," as indicated in the first Goebel decision at page 1087.

In Kumho, the Supreme Court elaborated on the Daubert gatekeeping function as applied to proposed expert testimony other than classic scientific testimony. The Court emphasized that even where the proposed expert testimony is not scientific in nature in the classical sense, the trial judge is nevertheless required to ascertain whether the expert "employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field," as indicated at page 152 of the Kumho decision.

In this case, the plaintiffs' motion in limine challenges both Dr. Evans' qualifications and his methodology, so it is necessary to analyze the matter under both parts of the Daubert and Rule 702 test.

The decision in Ralston, 275 F.3d 965, provides a good starting point with respect to evaluation of Dr. Evans' qualifications. The plaintiff in Ralston asserted that the warnings accompanying an implanted orthopedic nail were inadequate. The Court of Appeals affirmed the trial court's exclusion of the testimony of plaintiffs' expert, a board certified orthopedic surgeon, who was also an associate [37] professor of medicine. The expert's general credentials were clearly as good as reasonably could have been expected, but she had done no research specifically looking at the nail in question and had not drafted a warning for a surgical

device. Her general credentials, though seemingly impressive as general credentials, were not good enough. "Merely possessing a medical degree is not sufficient to permit a physician to testify concerning any medical-related issue," as the Court discussed at page 970. The board certified orthopedic surgeon's reliance on general principles and concepts, as the Court put it, did not suffice. The controlling Tenth Circuit cases exemplified by Ralston established that the expert's qualifications must be both adequate in a general qualitative sense as required by Rule 702 and specific to the matters he proposes to address as an expert.

Plaintiffs also challenge the reliability of Dr. Evans' expert testimony.

Under Rule 702, an expert with the necessary qualifications in the relevant field may give expert testimony, one, if the testimony is based on sufficient facts or data; two, if the testimony is the product of reliable principles and methods; and, three, the witness has applied the principles and methods reliably to the facts of the case, as indicated by Rule 702. And this is also generally discussed in the second Goebel decision, 346 F.3d 987, with the relevant portion at page 991.

[38] Daubert, of course, involved a proffer of expert testimony in a classical scientific discipline, epidemiology. The Court provided a non-exclusive list of five factors which were provided by the Court to guide trial court determinations of reliability. I will not repeat those lists—those factors here. Counsel are well aware of them.

Kumho made it clear that the gatekeeper function applies even where the proposed expert testimony is

outside the realm of science in the classical sense, as I have discussed. As noted by the Advisory Committee in commenting on the 2000 amendments to Rule 702, courts both before and after Daubert have found other factors relevant in determining whether expert testimony is sufficiently reliable to be considered by the jury. Those additional factors are listed in the comments to Rule 702 and I will not repeat them here.

In sum, the Daubert assessment of reliability is a determination of whether the conclusions to be expressed by an expert possessed of the necessary qualifications in the relevant field are the product of application of that expertise using recognized and supportable methodologies on the basis of adequate data which is rationally tied to the opinions which purport to be based on that data.

As indicated in the second Goebel decision, 346 F.3d at 992, "Under Daubert, any step that renders the analysis unreliable renders the expert's testimony inadmissible. This [39] is true whether the step completely changes a reliable methodology or merely misapplies that methodology." To the same general effect is Mitchell v. Gencorp, 165 F.3d 778, with the relevant discussion at page 782, a Tenth Circuit decision from 1999.

I reject plaintiffs' challenge to Dr. Evans' qualifications. Dr. Evans' CV is in evidence as Defendants' Exhibit 35 and I will not repeat that information here. His qualifications go far beyond those of an everyday pharmacist and his clinical experience is an obvious adjunct of his academic attainments, at least as relevant to this case.

I might add that Dr. Sasich, called by the plaintiffs, freely went beyond pharmacological topics and

expounded on physiology and to some extent clinical medical practice based substantially on his searches of literature he considered to be relevant. Dr. Evans' considerable qualifications satisfy me that he should be accorded the same leeway.

It is necessary to evaluate the reliability of Dr. Evans' expert testimony only to the extent that the portions of his testimony that I cite in this ruling have been made explicitly—have been explicitly challenged by plaintiffs in their motion in limine. For that reason, there is no need to engage in a reliability analysis of all of the matters testified to by Dr. Evans or discussed in his report and there is no need to dwell on the fact that he misplaced a decimal point in one of [40] his observations about the possible lethal effect of midazolam.

Those aspects of Dr. Evans' testimony, upon which I principally rely, are his findings with respect to the risk that a 500 milligram dose of midazolam will fail to induce a state of unconsciousness and his criticisms of the contention that there is a ceiling effect that is relevant to the determination of whether the prisoner will experience pain after IV administration of 500 milligrams of midazolam. His commentary in part 7 of his report about brain-dead patients and involuntary movements is of no moment to my ruling. With respect to the issue of whether Lockett's movements were voluntary or involuntary, the fact is that he, in all probability, had far less than 500 milligrams of midazolam in his circulatory system at the time he moved after being pronounced unconscious.

I find that Dr. Evans was well-qualified to give the expert testimony that he gave and that to the extent that his testimony was challenged in the motion in limine and relied upon by the Court in this ruling, his

testimony was the product of reliable principles and methods reliably applied to the facts of this case. The motion in limine with respect to Dr. Evans, Docket Entry Number 161, is denied.

I will now address the nature and characteristics of midazolam.

NATURE AND CHARACTERISTICS OF MIDAZOLAM

[41] With respect to the actual characteristics, effects, and preferred clinical uses of midazolam, the experts on the two sides of this case were in substantial agreement.

Midazolam is a short-acting benzodiazepine, which is most commonly used as a pre-anesthetic agent for routine medical procedures. Midazolam is approved by the Food and Drug Administration for sedation and induction of general anesthesia to be used before administration of other anesthetic agents. It can be used to alleviate patient apprehension, to eliminate the patient's memory of a procedure, and to induce anesthesia. It is not intended for use as a pain reliever. It is not an analgesic. In that respect, midazolam does not behave like an opiate or narcotic medications. It does have the effect of depressing the central nervous system at least when administered in a large dose. It begins to take effect quite quickly after introduction into the blood stream. It crosses the blood brain barrier and reaches maximum effects within 20 to 60 minutes.

The 500 milligram dosage of midazolam, as called for in Charts C and D of the revised protocol, is many times higher than a normal therapeutic dose of midazolam. When midazolam is administered in that quantity, it will result in central nervous system

depression as well as respiratory arrest and cardiac rest. In the dosage called for by the revised protocol, midazolam, although not an analgesic, is highly [42] likely to render the person unconscious and insensate during the remainder of the procedure. Consequently, analgesia, from midazolam or otherwise, is not necessary.

The proper administration of 500 milligrams of midazolam, as specified in Chart D, would make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs—or from the administration of the second and third drugs in Chart D, assuming that proper intravenous access has been established. The administration of a 500 milligram dose alone would be likely to cause death by respiratory arrest within an hour and probably closer to 30 minutes. This is because midazolam is water soluble. And as I have mentioned, it crosses the blood brain barrier very quickly.

There were some noteworthy areas of agreement between Dr. Evans and Dr. Lubarsky with respect to the anesthetic effect of midazolam. Dr. Lubarsky testified that an IV dose of 500 milligrams of midazolam would produce unconsciousness in "no more than a couple of minutes." That is at page 117 of the transcript. As to the level of unconsciousness needed, for instance, to render a prisoner insensate for purposes of setting a femoral IV line, Dr. Lubarsky testified that "midazolam unconsciousness is actually sufficient." That is at page 133 of the transcript. This is noteworthy not because [43] midazolam was used for that purpose with Lockett but because setting a femoral line entails "digging deeper into the tissue," as

described by Dr. Lubarsky, "a couple of inches below the skin's surface," as indicated at page 150 of the transcript.

Plaintiffs contend that there is a certain dosage level beyond which incremental increases in midazolam dosage would have no corresponding incremental effect. In pharmacological terms, this is called "the ceiling effect." As described by Dr. Sasich and Dr. Lubarsky, midazolam has a ceiling effect which prevents an increase in dosage from having a corresponding incremental effect on anesthetic depth. However, Dr. Evans testified persuasively, in substance, that whatever the ceiling effect of midazolam may be with respect to anesthesia, which takes effect at the spinal cord level, there is no ceiling effect with respect to the ability of a 500 milligram dose of midazolam to effectively paralyze the brain, a phenomenon which is not anesthesia but does have the effect of shutting down respiration and eliminating the individual's awareness of pain. The dosage at which the ceiling effect may occur at the spinal cord level is unknown because no testing to ascertain the level at which the ceiling effect occurs has been documented.

The use of midazolam presents a risk of paradoxical reactions or side effects such as agitation, involuntary [44] movements, hyperactivity, and combativeness. According to the product label for midazolam, these reactions may be the result of inadequate or excessive dosing or improper administration of midazolam. The likelihood that a paradoxical reaction will occur in any particular instance is speculative, but it occurs with the highest frequency in low therapeutic doses. Dr. Evans estimated that with a low therapeutic dose of midazolam there would be less than a 1 percent incidence of a paradoxical reaction. Dr. Sasich could

not say whether the incidence of a paradoxical reaction in the Oklahoma inmate population would be toward the low end or the high end of the range of incidence of that effect as documented in the literature. No data are available to show what the paradoxical reaction would be or the likelihood of a paradoxical reaction would be with a 500 milligram IV dose of midazolam.

The evidence falls well short of establishing that the risk of a paradoxical reaction at a 500 milligram IV dosage presents anything more than a mere possibility in any given instance that midazolam will fail to deliver its intended effect.

Based on the impressive record of pentobarbital and sodium thiopental, in a long series of executions by lethal injection in Oklahoma and other states, there is little room for doubt that pentobarbital and sodium thiopental would be preferable as the first drug in a three-drug protocol. With midazolam, there [45] may be some incrementally greater risk than with pentobarbital or sodium thiopental that the inmate will sense pain as a result of the injection of vecuronium bromide and the potassium chloride but will not have the ability to express the fact that he senses pain. How much greater that risk is, nobody knows, but some added element of risk of pain may be present with midazolam as opposed to pentobarbital or sodium thiopental.

Ironically, the very efficacy of pentobarbital and sodium thiopental for use in lethal injection has resulted in their unavailability for use by the Department of Corrections for lethal injection purposes. If either pentobarbital or sodium thiopental were available, Director Patton would have selected them rather than the midazolam protocols.

On this point, I am mindful that the Supreme Court in Baze v. Rees, 553 U.S. 35, a decision from 2008, made it clear that this Court is not to sit as "a board of inquiry charged with determining best practices for executions." That's at page 51 of the Baze decision.

I'll now comment with respect to the capabilities or properties of vecuronium bromide.

VECURONIUM BROMIDE

Vecuronium bromide is a neuromuscular blocking agent. The accounts of the Lockett execution which indicate that he began to move after the beginning of the administration of vecuronium bromide indicate that at that point he had not been paralyzed [46] by the neuromuscular blocking effect of vecuronium bromide.

From all the evidence before the Court, I conclude that the implementation of lethal injection per Chart D does not carry a substantial likelihood of inflicting severe pain.

We'll now take a ten-minute recess.

(RECESS HAD.)

THE COURT: I'll now summarize the claims asserted by the plaintiffs for preliminary injunction purposes.

CI AIMS ASSERTED BY THE PLAINTIFFS FOR PRELIMINARY INJUNCTION PURPOSES

The amended complaint filed on October 31, 2014, pleads claims divided into eight counts, some of which, as might be expected, are interrelated. Five of those counts, specifically Counts 2, 4, 5, 7, and 8, are asserted for preliminary injunction purposes as shown

by the motion for preliminary injunction at Docket Entry Number 92.

In Count 2, the preliminary injunction plaintiffs assert that the use of midazolam would constitute cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.

Count 4 asserts violations of the Eighth and Fourteenth Amendments based on what plaintiffs describe as "unsound procedures and inadequate training," as indicated at page 28 of Docket Entry Number 75. Under this heading, plaintiffs assert that the failure of Defendants Patton and Trammell "to seek out [47] expert assistance has resulted in execution procedures that create a substantial risk of severe pain, needless suffering, and a lingering death," as indicated at paragraph 137.

Count 4 also complains that ultimate authority to supervise the execution process and make decisions about the process is vested in the Defendant Patton without "appropriate checks and balances to ensure against severe pain, needless suffering, and a lingering death during the execution process." That is at paragraph 155.

Plaintiffs further assert that as a result of these failures, among others, there is "a substantial risk that the procedures will not be administered as written." That's paragraph 156.

Referring to the revised protocol, plaintiffs assert in paragraph 160 that "if the attempted executions of plaintiffs are allowed to proceed in accordance with the deficient procedures identified above, plaintiffs will be subjected to cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments to the United States Constitution."

In Count 5, under "Notice and Opportunity to be Heard, Right to Counsel and to Petition the Courts," plaintiffs point out that under the revised protocol, the offender will be notified only ten calendar days before the date of execution of the drugs to be used and as to whether they will be compounded. This is paragraph 163.

[48] In this count, plaintiffs also assert that the revised protocol allows Defendant Patton "to deviate from any of those procedures at will and without notice, thereby making the written instrument virtually meaningless as a form of notice." That is paragraph 164. On this basis, plaintiffs conclude in Count 5 that by "failing to require and provide meaningful and effective notice of how plaintiffs will be executed," defendants are depriving the plaintiffs of their right to notice and an opportunity to be heard in violation of the Due Process Clause of the Fourteenth Amendment and are subjecting plaintiffs to cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments, as indicated in paragraph 169.

Count 7 is an Eighth Amendment claim predicated on "experimentation on captive human subjects." Plaintiffs assert that by "attempting to conduct executions with an ever-changing array of untried drugs of unknown provenance, using untested procedures, defendants are engaging in a program of biological experimentation on captive and unwilling human subjects," as indicated at paragraph 184. In support of this allegation, plaintiffs cite the experience with the execution of Clayton Lockett, which they assert was "a failure that produced severe pain, needless suffering, and a lingering death," at page—at paragraph 184.

Under this heading, plaintiffs further assert that the [49] defendants lack the scientific skills necessary to design an execution procedure that does not inflict severe pain, needless suffering, or a lingering death and that defendants have failed to test their lethal drugs and execution procedures on non-human animals before using them on captive and unwilling human subjects as pleaded at paragraphs 187 and 188. On this basis, plaintiffs assert that if the attempted executions of plaintiffs are allowed to proceed plaintiffs will be subjected to cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

In Count 8, plaintiffs assert a violation of their "right of access to information, to counsel, and to the courts." Under this heading, plaintiffs assert a violation of their rights as a result of the defendants' "deliberate concealment of information that would enable plaintiffs to determine how defendants intend to carry out their death sentences, including by failing to disclose in advance of the execution details about the drugs used, the rationale for the selection of these drugs and their dosages, the qualifications and training of the persons administering them, and defendants' ability to respond and prepare for responding to complications," as pleaded at paragraph 195.

They assert a violation of their right to petition the government for redress of their grievances as well as a denial of their right to counsel, which they assert exists "during [50] every stage of any attempt to execute" the plaintiff. That is at paragraph 198. As for violation of the right to counsel, plaintiffs assert, in substance, that plaintiffs' counsel must be permitted to observe all steps of the execution process from the

time that the offender is brought into the execution chamber until the offender is pronounced dead. That is at page 207.

Plaintiffs also assert that their counsel "must be able to communicate with the courts as to any problems or deviations that occur during the execution that impact plaintiffs' substantial rights." That is at paragraph 208. For these reasons, among others, plaintiffs assert in Count 8 that execution under the revised protocol would violate their rights under the First and Fourteenth Amendments to the United States Constitution and under 18 United States Code, Section 3599, as indicated in paragraph 218.

I will now address the standards for entry of a preliminary injunction.

STANDARD FOR ENTRY OF A PRELIMINARY INJUNCTION

To establish that preliminary injunctive relief is appropriate, plaintiffs must demonstrate, first, that they will likely succeed on the merits of their claim; second, that without preliminary relief they will suffer irreparable harm; third, that the balance of equities tips in their favor; and, fourth, that entry of an injunction is in the public interest.

[51] That is all as discussed by our Court of Appeals in Kikumura v. Hurley, 242 F.3d 950, with the relevant discussion at page 955. That's a decision from the Tenth Circuit in 2001.

The injunctive relief the plaintiffs seek here is not in the disfavored category, so there is no basis for the Court to apply the heightened standard that would govern if the injunctive relief sought by plaintiffs were in one of the disfavored categories. As indicated by the

Court of Appeals in the Kikumura decision, citing Otero Savings & Loan Association v. Federal Reserve Bank of Kansas City, 665 F.2d 275, with the relevant discussion at page 278, a decision from the Tenth Circuit in 1981. When the other three requirements for a preliminary injunction are satisfied, "it will ordinarily be enough that the plaintiff has raised questions going to the merits so serious, substantial, difficult, and doubtful as to make them a fair ground for litigation." That is at page 955 of the Kikumura decision.

CONCLUSIONS OF LAW

I will now state my conclusions of law. I don't think it would be particularly helpful to the parties or to a reviewing court for me to simply declare some abstract principles of law, most of which are well-established. What is decisive in this case is the application of those principles to the facts of this case. That will be my main focus. And that will require some discussion of the facts as I state my conclusions of law.

[52] As I have already mentioned, the motion now before the Court involves five of the eight counts in the amended complaint; namely, Counts 2, 4, 5, 7, and 8. I will discuss those in the order in which they appear in the amended complaint.

I will first address Count 2, which is the Eighth Amendment claim relating to midazolam.

COUNT 2 - EIGHTH AMENDMENT - MIDAZOLAM

In Count 2, plaintiffs assert that their Eighth Amendment right to be free of cruel and unusual punishment would be violated if, in the execution process, midazolam—if, in the execution process, midazolam is used as provided in the revised protocol.

Other drugs, such as sodium thiopental, have been used as the first drug in the execution sequence with a longer record than midazolam has of reliably producing the desired effect. For that reason, it is not necessary to look past sodium thiopental to say with considerable confidence that if all of the—if all of the potentially usable anesthetic and sedative agents produced by the pharmaceutical industry were equally available to the DOC, it is not likely that midazolam would be the first choice. Director Patton's testimony makes that clear. This makes it especially important to proceed with a thorough understanding of the standard established by the Supreme Court in Baze v. Rees.

[53] Baze v. Rees, 553 U.S. 35, a decision, as I have mentioned, from 2008, came to the Supreme Court from Kentucky where the protocol called for the administration of 3,000 milligrams of sodium thiopental, 50 milligrams of pancuronium bromide, and 240 milliequivalents of potassium chloride. The Kentucky protocol before the Supreme Court in Baze v. Rees provided for IV insertion by "qualified personnel having at least one year of professional experience." That is 553 U.S. at page 45. In practice, Kentucky used a certified phlebotomist and an emergency medical technician to perform the venipunctures necessary for the catheters, as indicated at page 45. The protocol allowed up to one hour within which to establish both primary and secondary peripheral intravenous sites in the arm, leg, hand, or foot of the inmate, as indicated also on page 45.

In Baze, the Court noted as a preliminary matter that "it is uncontested that failing a proper dose of sodium thiopental that would render the prisoner

unconscious, there is a substantial constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride," as discussed at page 53. In Baze, the prisoner asserted, among other things, that the protocol was deficient because it was "possible that the IV catheters will infiltrate into surrounding tissue causing an inadequate dose to be delivered to the vein because of [54] inadequate facilities and training and because Kentucky has no reliable means of monitoring the anesthetic depth of the prisoner after the sodium thiopental has been administered." And that is at page 54.

Under the Kentucky protocol, the warden and deputy warden, who apparently were not subject to any particular training requirements, were charged with the responsibility to "watch for any problems with the IV catheters and tubing," as discussed at pages 45 and 46. In the Kentucky procedure, the physician was prohibited from participating in conducting the execution other than to certify the cause of death, as also discussed on page 46.

It also fell to the warden and the deputy warden, "through visual inspection," to determine whether the prisoner had become unconscious within 60 seconds following the delivery of the sodium thiopental to the primary IV site, as discussed on page 45.

The plurality opinion in Baze was written by Chief Justice Roberts and was joined by Justices Kennedy and Alito. Justices Stevens, Scalia, Thomas, and Breyer concurred in the judgment. As indicated by the concurring opinion of Justice Thomas, with whom Justice Scalia joined, Justices Scalia and Thomas would find an Eighth Amendment violation only if a method of execution "is deliberately designed to inflict

pain," as discussed on page 94. The Supreme Court's decision in Marks v. [55] United States, 430 U.S. 188, from 1977, tells us at page 193 that where there is a fractured decision of the Supreme Court, the Court's holding is the position taken by those members of the Court who concurred in the judgment on the narrowest grounds. Since the position taken in Baze by Justices Scalia and Thomas was noticeably less exacting than the position taken by the Chief Justice and Justices Kennedy and Alito in the plurality opinion, the Court's holding in Baze is to be found in the plurality opinion.

Before getting into the holdings in Baze, one other aspect of that decision should be noted. In Baze, the petitioner's arguments centered mainly on the asserted risk of improper administration of sodium thiopental, which would potentially leave the prisoner conscious when the second and third chemicals are administered. Counsel for the petitioner in Baze acknowledged at oral argument that proper administration of the first drug, sodium thiopental, would eliminate any meaningful risk that the prisoner would experience pain from the subsequent injections of the second and third drugs, as discussed on page 49.

In contrast, in the matter now before this Court, plaintiffs assert both the risk of maladministration of the drugs and that the first drug, midazolam, is, in any event, unreliable as an anesthetic agent. The holdings in Baze are nevertheless instructive and certainly binding on this Court [56] because regardless of the source of the risk, the Baze decision was all about risk and how we evaluate that risk for Eighth Amendment purposes.

After a detailed analysis of the Kentucky lethal injection protocol, viewed in light of the Supreme

Court's precedence, the plurality in Baze summarized the applicable standard as follows: "A stay of execution may not be granted on grounds such as those asserted here unless the condemned prisoner establishes that the state's lethal injection protocol creates a demonstrated risk of severe pain. He must show that the risk is substantial when compared to the known and available alternatives. A state with a lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard," as this Court stated at page 61.

In closing argument in this case last Friday, plaintiffs argued that Baze is distinguishable from this case in a way that makes the holding in Baze with respect to "known and available alternatives" inapplicable in this case. I disagree. It is true that this case involves both the risk that the first drug will not have its intended effect even if delivered in a massive IV dose and the risk that, due to a deficient technique, the massive IV dose will not, in fact, be delivered as intended.

In the section of the plurality opinion on page 61 in [57] which the Supreme Court made reference to comparison with "known and available alternatives," the Court was speaking broadly in terms of whether the prisoner had established "that the state's lethal injection protocol creates a demonstrated risk of severe pain." In stating that the prisoner "must show that the risk is substantial when compared to the known and available alternatives," the Court did not differentiate between the two types of risks.

On this point, I would also note that this reading of Baze is also borne out by common sense. It is extremely unlikely that the Supreme Court would establish a constitutional doctrine that would enable a

condemned inmate to block his execution on Eighth Amendment grounds with no consideration by the Court of alternatives which by way of comparison demonstrate the constitutional unacceptability of the risk complained of by the prisoner. Logic tells us that alternatives are relevant in determining whether there is a constitutionally impermissible quantum of risk regardless of the source of the risk.

In reaching its conclusions in Baze, the Court made several other observations which are of varying degrees of relevance on the facts of this case.

First, it is significant, at least at a high level of generality, that the Court in Baze noted that the Supreme Court had never invalidated a state's chosen procedure for carrying [58] out a sentence of death as the infliction of cruel and unusual punishment, as discussed at page 48. The Court also stated unequivocally that simply because an execution method may result in pain, either by accident or as an inescapable consequence of death, does not establish the sort of objectively intolerable risk of harm that qualifies as cruel and unusual within the meaning of the Eighth Amendment, as discussed at page 50.

Elaborating on that point, also on page 50, the Court told us that an isolated mishap alone does not give rise to an Eighth Amendment violation precisely because such an event, while regrettable, does not suggest cruelty or that the procedure gives rise to a substantial risk of serious harm. Because Baze, like the case now before this Court, is really all about risk and how we evaluate and attribute significance to that risk, it is also helpful to bear in mind the risks which individually and collectively were insufficient to support granting relief to the petitioner in Baze.

The petitioner in Baze asserted that there was a risk of improper administration of the lethal injection drugs because the doses were difficult to mix into solution and to load into the syringes, the protocol failed to establish a rate of injection, there was a risk of infiltration of drugs into the surrounding tissue, Kentucky's execution facilities and training of the execution team were inadequate, and there was [59] no reliable means of monitoring the anesthetic depth the prisoner had reached, all as discussed on page 54. These risks, individually and collectively, were insufficient to support a grant of relief in Baze.

As a necessary corollary to its main holding in Baze, the Court also stated unequivocally that "an inmate cannot succeed on an Eighth Amendment claim simply by showing one more step the state could take as a fail-safe for other independently adequate measures," as discussed on pages 60 and 61. The Supreme Court expressly rejected the notion that federal courts should, in effect, sit as "boards of inquiry charged with determining best practices for executions with each ruling supplanted by another round of litigation, touting a new and improved methodology, as discussed at page 51. The Court expressly noted that the best practices approach "calling for the weighing of relative risks without some measure of deference to a state's choice of execution procedures would involve the courts in debatable matters far exceeding their expertise," as discussed in note 2 on page 51.

In her dissenting opinion, Justice Ginsburg lamented that there were several shortcomings in the Kentucky protocol that, in her view, regrettably did not make any difference to the majority. This included the lack of safeguards to determine whether the inmate was unconscious before injection of the second

and third drugs, the fact that only the warden and the [60] deputy warden remained in the execution chamber after placement of the catheters, the lack of any medical training on the part of the warden and the deputy warden, the reliance only on visual observation to determine whether the inmate appeared to be unconscious, and the failure to use reflex tests or noxious stimulus to determine whether the prisoner was unconscious. Those matters were discussed by Justice Ginsburg on pages 114 and 118.

The Tenth Circuit has had more than one opportunity to apply the principles established in Baze. The best example would be the decision in Pavatt v. Jones, 627 F.3d 1336, a Tenth Circuit decision from 2010.

In Pavatt, at pages 1338 and 39, the Tenth Circuit said—and here I am leaving out citations and internal quotations. "In Baze, the Court acknowledged that subjecting individuals to a risk of future harm, not simply inflicting pain, can qualify as cruel and unusual punishment. However, the Court emphasized to establish that such exposure violates the Eighth Amendment, the conditions presenting the risk must be sure or very likely to cause serious illness and needless suffering and give rise to sufficiently imminent dangers."

In Pavatt, the Tenth Circuit also noted that in Baze the Supreme Court held that simply because an execution method may result in pain, either by accident or as an inescapable consequence of death, does not establish the sort of [61] objectively intolerable risk of harm that qualifies as cruel and unusual. Likewise, the Tenth Circuit noted that in Baze the Supreme Court held that a stay of execution may not be granted "unless the condemned prisoner

establishes that the state's lethal injection protocol creates a demonstrated risk of severe pain and that the risk is substantial when compared to the known and available alternatives." That is at page 1339 of the Pavatt decision quoting Baze at page 61. On this point, it is noteworthy that in Pavatt the prisoner, Jeffrey Matthews, was asserting a drug-related risk, not a risk of maladministration.

One of the things that is clear from the Baze decision, especially as that decision was applied by the Tenth Circuit in Pavatt, is that if the risk asserted by the prisoner is very speculative at all that speculative element will drain away the constitutional significance of the risk. A good example of this is the treatment of an Arizona prisoner's claims by the Arizona District Court, the Ninth Circuit, and the Supreme Court.

In Landrigan v. Brewer, 2010 West Law 4269559, from the District of Arizona on October 25th of 2010, the plaintiff asserted that there was an unconstitutional risk of harm flowing from the state's proposed use of drugs from a foreign source that was not approved by the FDA. The plaintiff asserted that the foreign supply of sodium thiopental might be [62] contaminated with toxins that could cause pain and could fail to properly anesthetize the plaintiff resulting in excruciating pain when the second and third drugs are administered.

The district court agreed that the prisoner had raised significant issues about the efficacy of the non-FDA-approved sodium thiopental and granted a stay of execution. The stay was affirmed by the Ninth Circuit at 625 F.3d 1144. The Supreme Court promptly vacated the stay in a one-paragraph opinion. Brewer v. Landrigan, 131 Supreme Court 445, from

2010. Of note here, the Supreme Court, quoting its decision in Baze, in part, said that "there is no evidence in the record to suggest that the drug obtained from a foreign source is unsafe. The district court granted the restraining order because it was left to speculate as to the risk of harm. But speculation cannot substitute for evidence that the use of the drug is sure or very likely to cause serious illness and needless suffering." Those are the words of the Supreme Court.

Thus, the Supreme Court's subsequent treatment of its decision in Baze makes it unmistakably clear that a speculative assertion of a risk of harm cannot substitute for a showing "that the use of the drug is sure or very likely to cause serious illness and needless suffering."

I'm also influenced by the Sixth Circuit's opinion in Cooey v. Strickland, 589 F.3d 210, a Sixth Circuit decision from 2009, in part because of the very thoughtful opinion [63] written for the Court by Circuit Judge Julia Smith Gibbons and in part because that case involving an Ohio execution arose against the backdrop of a serious mishap that had occurred in another execution in Ohio.

Cooey v. Strickland was decided on December 7, 2009, one day before the plaintiff in that case, Kenneth Biros, was scheduled for execution. On September 15, 2009, slightly less than three months before the Sixth Circuit's decision in Cooey, the state of Ohio unsuccessfully attempted to execute Romell Broom. As explained by the Court of Appeals in Cooey, "The execution team was unable to find a vein on Broom's arm after repeated attempts over two hours. They attempted to insert the IV catheter into the crook of Broom's elbow, his wrists, over the knuckle of his first

finger, and near his ankle. Twice the team managed to insert a catheter that was not secured properly and caused bleeding." That's 589 F.3d at page 224, note 3.

Citing the unsuccessful attempt to execute Biros, as well as other allegedly unconstitutional revisions to the Ohio protocol, Biros sought a stay of execution. He asserted that there was an undue risk of improper implementation of the Ohio protocol which would lead to severe pain, that Ohio employed untrained and insufficiently competent medical personnel, that there was a lack of supervision of the execution process by a licensed physician, and that there was a lack of a prescribed time limit within which to establish IV access, among other [64] complaints, as indicated on page 223.

On the issue of the risk of maladministration, the unfortunate experience in the Broom execution figured heavily into the arguments advanced by Biros. As explained by the Fifth Circuit, "Biros relies heavily on Ohio's halted execution of Broom to distinguish his case from that of Baze," as stated on page 224.

The Sixth Circuit concluded that the unfortunate and very recent experience with the Broom execution, which, from the available information, could fairly be called a botched execution, did not take Biros' claim out of the realm of speculation. Citing Clemons v. Crawford, 585 F.3d 1119, an Eighth Circuit decision from 2009, the Sixth Circuit noted that the Eighth Circuit had "rejected the prisoner's claim that there was a substantial risk of pain due to incompetent personnel despite the fact that the Court had previously found that medical personnel administering the protocol, since removed, had been incompetent," as stated at page 225. The Sixth Circuit concluded that "for the same reasons, we cannot assume that the

same misfortunes that befell Broom will befall Biros," as stated at page 225.

On the basis of the record before it, including the wholly unsuccessful attempt to execute Romell Broom, the Sixth Circuit held that "speculations or even proof of medical negligence in the past or in the future are not sufficient to render a [65] facially constitutionally sound protocol unconstitutional." That is the Cooey decision at page 225.

I conclude, as a matter of law, that the revised lethal injection protocol adopted by the Oklahoma Department of Corrections effective September 30, 2014, is facially constitutional when measured by the principles promulgated in Baze v. Rees, as further explained by our Court of Appeals in Pavatt v. Jones.

Citing the experience with the execution of Clayton Lockett, these plaintiffs assert, in substance, that there is not a constitutionally sufficient degree of assurance that the revised protocol, even if it is constitutional on its face, will be administered in a way which will avoid the infliction of serious pain. This contention obviously requires the Court to assess probabilities with respect to future events, some of which are within the control of humans, albeit fallible humans, and some of which are decidedly not within the control of anyone.

I conclude on the basis of the evidence before me that plaintiffs have failed to establish that proceeding with the execution of these plaintiffs on the basis of the revised protocol presents a risk that is "sure or very likely to cause serious illness and needless suffering," amounting to "an objectively intolerable risk of harm," in the words of the Supreme Court at page 50 of the Baze decision.

[66] In reaching this decision, I place considerable reliance, and I'm going to say again considerable reliance, on three aspects of the DOC's lethal injection protocol. The first is the requirement that both primary and backup IV access sites be established. The second is that confirmation of the viability of the IV sites is specifically required. The third is that the offender's level of consciousness must be monitored throughout the procedure.

The predominant risk asserted by the plaintiffs in this case is that midazolam will not have its intended effect as the first drug in the series, thus leading to injection of vecuronium bromide or rocuronium bromide and potassium chloride into a sensate person either because of the asserted limitations of midazolam or because it is not effectively administered in a massive IV dose. The three safeguards to which I have referred will reduce the risk of injection of the second and third drugs into a sensate person to well below a level that would establish a right to relief under Baze v. Rees.

The conclusions I have reached establish that plaintiffs have failed to show a probability of success on the merits of Count 2. However, wholly apart from that, there is a separate reason for which plaintiffs have failed to establish a probability of success on the merits of Count 2.

In proposing that they be executed with a lethal dose of [67] sodium thiopental, as they assert at paragraph 31 of their amended complaint, plaintiffs have failed to provide a comparison with, in the words of the Supreme Court, a "known and available alternative." That is from page 61 of the Baze decision. On this issue, the burden of proof is immaterial. Because aside from plaintiffs' failure to demonstrate a known

and available alternative, the defendants have affirmatively shown that sodium thiopental and pentobarbital, the only alternatives to which the plaintiffs have even alluded, are not available to the DOC.

In In Re Lombardi, 741 F.3d 888, an Eighth Circuit decision from earlier this year, the plaintiffs asserted that they were "not required to propose an alternative method of execution as an element of their Eighth Amendment claim." That's at page 895. The Eighth Circuit responded, in my view correctly, that this was "a plain misreading of the Supreme Court's decision in Baze v. Rees and the Eighth Amendment," also at page 895.

The Eighth Circuit, after quoting the passage in Baze, which requires comparison "to the known and available alternative," cited cases from the Fifth Circuit, Raby v. Livingston, 600 F.3d 552, with the relevant discussion at pages 560 and '61, a Fifth Circuit decision from 2010; and the Sixth Circuit, Cooey v. Strickland, which I have already discussed, for the proposition, with which I agree, that it is incumbent [68] upon a prisoner who challenges an execution protocol under Baze to demonstrate that the risk created by the challenged protocol is substantial when compared to the known and available alternatives. Indeed, in the Raby decision, 600 F.3d at page 561, the Fifth Circuit described this as "the second step of the Baze test."

The only alternative short-acting barbiturate proposed by the plaintiffs as an alternative to midazolam is sodium thiopental, as alleged in paragraph 31 of the amended complaint. But sodium thiopental became unavailable in the United States long before these plaintiffs proffered it in this case as

an alternative to midazolam. In Pavatt v. Jones, which I've already discussed, 627 F.3d at page 1338, the Tenth Circuit noted that "sodium thiopental is now effectively unobtainable anywhere in the United States, thus requiring Oklahoma and other death penalty states to revise their lethal injection protocols."

In Sepulvado v. Jindal, 729 F.3d 413, a Fifth Circuit decision from 2013, at page 416, the Fifth Circuit noted that sodium thiopental had been unavailable since 2010. In Chavez v. Florida, 742 F.3d 1267, at page 1274, an Eleventh Circuit decision from earlier this year, Chief Judge Carnes made the same observation in his concurring opinion in which he also noted that in 2013 the European Union threatened to limit the supply of propofol, which caused Missouri authorities to revise [69] Missouri's protocol. Judge Carnes concluded, I believe correctly, that "an alternative drug that its manufacturer or its distributor or the FDA will not allow to be used for lethal injection purposes is no drug at all for Baze purposes," as stated on page 1275.

I conclude as a matter of law that the plaintiffs' reliance on sodium thiopental as an alternative to midazolam is altogether unavailing because there has been no showing that sodium thiopental is, in fact, an available alternative.

Plaintiffs have failed to establish a probability of success on the Eighth Amendment cruel and unusual punishment claim asserted in Count 2.

I will now turn to Count 4, the Eighth Amendment claim asserting unsound procedures and inadequate training.

COUNT 4 - EIGHTH AMENDMENT UNSOUND PROCEDURES AND INADEQUATE TRAINING

With respect to execution procedures and training to prepare the execution team to competently perform an execution by lethal injection, the revised Oklahoma protocol is at least as protective of the prisoner's interests as the protocol which was before the Court in Baze.

The following aspects of the protocol which passed muster in Baze are noteworthy. The individuals inserting the IV catheters were only required to have at least one year of professional experience. The prisoner's state of consciousness [70] or unconsciousness is determined by the warden and the deputy warden through visual inspection. The duty to watch for problems with the IV catheters and the tubing fell to the warden and the deputy warden. The list of professional categories approved for IV insertion was identical to Oklahoma's list, specifically a certified medical assistant, a phlebotomist, an EMT, a paramedic, or a military corpsman. The Kentucky protocol called for at least ten practice sessions per year. The Kentucky protocol called for the IV Team to establish primary and backup lines and to prepare two sets of lethal injection drugs.

In Baze, the petitioners specifically faulted the Kentucky protocol for lacking a systematic mechanism for monitoring anesthetic depth, as indicated at page 58 of the Baze decision. They maintained that the visual inspection performed by the warden and deputy warden was an inadequate substitute for more sophisticated procedures they proposed, such as the use of various types of monitoring equipment, as discussed at page 59.

Moreover, the Supreme Court, citing the Tenth Circuit's decision in Hamilton v. Jones, 472 F.3d 814, with the relevant discussion at page 817, a Tenth Circuit decision from 2007, concluded that "the risks of failing to adopt additional monitoring procedures are thus even more remote and attenuated than the risks proposed by the alleged inadequacies of Kentucky's procedures designed to ensure the delivery of [71] thiopental." That is at page 59.

On this point, the plurality opinion rejected the dissent's argument that "rough and ready tests for checking consciousness, calling the inmate's name, brushing his eyelashes, or presenting him with strong noxious odors" was necessary in order to "materially decrease the risk of administering the second and third drugs before the sodium thiopental has taken effect," as discussed by the Court at page 60.

This led to the Supreme Court's conclusion that "an inmate cannot succeed on an Eighth Amendment claim simply by showing one more step the state could take as a fail-safe for other independently adequate measures. This approach would serve no meaningful purpose and would frustrate the state's legitimate interest in carrying out a sentence of death in a timely manner." That's at pages 60 and 61.

In Muhammad v. Crews, 2013 West Law 6844489, a decision from the Middle District of Florida about a year ago, late 2013, a decision which was affirmed at 739 F.3d 683 earlier this year, with certiorari denied, 134 Supreme Court 894, which was on January 7th of this year, the district court observed at star page 8 that "the Florida protocol requires that the execution team confirm that the inmate is unconscious after administration of the first drug, midazolam hydrochloride. Thus, if done correctly, there is no

substantial risk of harm [72] from administration of the second and third drugs."

Although this is not a conclusion of law, an additional comment with respect to Warden Trammell may be appropriate here. My sense of the matter from the evidence, including listening very carefully to the testimony of Warden Trammell, is that the experience of the Lockett execution was in some ways repugnant to Warden Trammell. I am persuaded that Warden Trammell does not want a mishap like this to ever occur again, at least on her watch. Granting that Warden Trammell may, in some ways, be subject to criticism for playing what was arguably an overly passive role in the run-up to the Lockett execution, I quite easily find that her skills as an administrator have already manifested themselves in the training regimen that has been implemented since last September and will be very evident in the preparations for the upcoming executions.

Plaintiffs have not satisfied the Court that the lethal injection procedures and training regimen that are now in place present any substantial risk of serious harm within the meaning of the Court's holdings in Baze v. Rees. I accordingly conclude that plaintiffs have failed to establish a probability of success on the Eighth Amendment unsound procedures and inadequate training claim asserted in Count 4.

I now proceed to consider the claim asserted in Count 5 relating to notice and opportunity to be heard asserted under [73] the Eighth and Fourteenth Amendments.

COUNT 5 NOTICE AND OPPORTUNITY TO BE HEARD EIGHTH AND FOURTEENTH AMENDMENTS

The heart of this claim is plaintiffs' assertion that ten days is not constitutionally sufficient notice to the prisoner of the DOC's intentions with respect to the specific drug combination to be used. This proposition is essentially moot as to these plaintiffs because they have been given a minimum of several weeks' notice of the combination of drugs that will be administered. In any event, ten days' notice would be sufficient, even if not optimal.

This claim is foreclosed by the reasoning of the Fifth Circuit in Sepulvado v. Jindal, 729 F.3d 413, with the relevant discussion at pages 418 through 420, and the Eleventh Circuit in Wellons v. Commissioner, 754 F.3d 1260, with the relevant discussion at page 1267, another decision from earlier this year. I agree with the analysis of the courts in both of those cases and further elaboration is not necessary.

I will add, however, that the ten-day provision is not without a sound rationale. Inmates and others have succeeded in a number of instances in securing embargoes to cut off the supply of chemicals used in lethal injection. In some situations, eleventh-hour litigation has virtually become the norm. That eleventh-hour litigation is intended to forestall, after years of litigation on the merits as well as clemency [74] proceedings, the execution of a validly imposed sentence of death, a penalty which itself has repeatedly been held to be constitutional. Those who are charged with the responsibility to carry out a sentence of death by lethal injection need the ability to avail themselves of other options on relatively short notice.

I accordingly conclude that plaintiffs have failed to establish a probability of success on the notice and opportunity to be heard claim asserted in Count 5.

I now turn to Count 7, the Eighth and Fourteenth Amendment claim asserting experimentation on human subjects.

COUNT 7 - EIGHTH AND FOURTEENTH AMENDMENTS - EXPERIMENTATION ON HUMAN SUBJECTS

In this count, plaintiffs complain that the use of untried drugs by way of untested procedures will cause them to experience severe pain, needless suffering, and a lingering death.

In the Baze decision, at page 62, the Supreme Court stated, and here I am leaving out an internal citation, "Throughout our history, whenever a method of execution has been challenged in this Court as cruel and unusual, the Court has rejected the challenge. Our society has nonetheless steadily moved to more humane methods of carrying out capital punishment. The firing squad, hanging, the electric chair, and the gas chamber have each, in turn, given way to more humane [75] methods, culminating in today's consensus on lethal injection. The broad framework of the Eighth Amendment has accommodated this process toward more humane methods of execution and our approval of a particular method in the past has not precluded legislatures from taking the steps they deem appropriate in light of new developments to ensure humane capital punishment. There is no reason to suppose that today's decision will be any different." That is from page 62 of the Baze decision.

Thus, as the Sixth Circuit pointed out in Cooey, to which I've already referred more than once, 589 F.3d at page 229, "that the procedure has never before been used, does not itself establish that the procedure is cruel and unusual. The Supreme Court has previously

considered various modes of execution and has yet to find one violative of the Eighth Amendment." In short, I conclude that the Eighth Amendment does not immunize an individual from being the first person to be subjected to a new method of execution.

Count 7 fails as a factual matter and as a matter of law. As a factual matter, by plaintiffs' own count, execution with midazolam as part of a three-drug protocol has been accomplished 12 times. That's the plaintiffs' pleading at Docket Entry Number 159, page 58. This is not a new method, at least in the sense required for the Court to regard its use as human experimentation.

As a matter of law, the basic Baze test still controls. [76] These plaintiffs must establish that the state's lethal injection protocol creates a demonstrated risk of severe pain and that the risk is substantial when compared to the known and available alternatives. They have failed to do so.

I accordingly conclude that plaintiffs have failed to establish a probability of success on the human experimentation claim asserted in Count 7.

I now turn to the Count 8 claim relating to a right of access to information, counsel, and the courts.

COUNT 8 - RIGHT OF ACCESS TO INFORMATION, COUNSEL, AND THE COURTS

This claim is based on the First and Fourteenth Amendments. From plaintiffs' motion, Docket Entry Number 92 at page 15, and their preliminary hearing brief, Docket Entry Number 160 at page 7, it appears that plaintiffs assert a right essentially to have counsel physically present as a legal proctor of the IV insertion process. This conjures up an untenable scene

in which the prisoner's counsel is standing at the gurney, cell phone in hand, ready to dictate the information necessary to fill in the blanks on an emergency ex parte motion for stay if he or she takes issue with any part of the process as it unfolds.

The reality is that as execution by lethal injection is actually carried out, the prisoner's erstwhile right of access to the courts must, of necessity, give way to the execution [77] team's discharge of its duties as long as those who are carrying out the process are operating within the confines of a constitutionally sound lethal injection protocol. And I hasten to add that it would appear from plaintiffs' contention as to the very closeness of the scrutiny that they say is constitutionally required that protection of the identities of the execution team members would likely be impossible.

On this claim, I agree with the reasoning of Judge Wake of the District of Arizona in Towery v. Brewer, 2012 Westlaw 592749, from the District of Arizona, February 23, 2012, at star page 18, a decision that was affirmed by the Ninth Circuit at 673 F.3d 650, and here I'm leaving out internal citations and quotes. "Prisoners have a constitutional right of access to the courts that is adequate, effective, and meaningful. However, this right guarantees no particular methodology but rather the conferral of a capability. The capability of bringing contemplated challenges to sentences or conditions of confinement before the courts. Consequently, an inmate who brings a Section 1983 claim based on his right of access to the courts must be able to show that the infringing act somehow defeated his ability to pursue a legal claim. That is, a prisoner must show he suffered an actual injury as a result of the defendant's actions." That's at pages 348

and 49. "An actual injury is actual prejudice with respect to contemplated or existing litigation such as the inability to meet a filing [78] deadline or to present a claim. The right of access does not create an abstract freestanding right but exists to vindicate other rights."

No court has found a constitutional right for the prisoner to have counsel present to supervise the IV insertion process and I decline to be the first judge to so hold.

In Count 8, plaintiffs also assert a First Amendment right of access to information about their planned executions, as indicated in Docket Entry Number 92 at page 15, Docket Entry Number 160 at page 9, and Docket Entry Number 159 at pages 71 through 75.

I conclude that plaintiffs' reliance on the First Amendment is misplaced. The interests that plaintiffs, as prison inmates facing execution, would protect under this heading are protected to the extent that they are protected at all under the Due Process Clause of the Fourteenth Amendment and perhaps arguably under the Eighth Amendment as made applicable to the states through the Fourteenth Amendment. Measured by these provisions, the plaintiffs' right of access to information about their impending executions is adequately protected by the revised protocol, as I have already discussed.

To the extent that plaintiffs seek to avail themselves of the public's right of access to executions in Oklahoma, I conclude that even if they had standing to tie their claims to the general public's right of access, their claim would fail [79] substantially for the reasons articulated last Friday by Judge Heaton in Oklahoma Observer v. Patton, Case Number Civil 14-

0905, his order being Docket Entry Number 48 in that case.

I accordingly conclude that plaintiffs have failed to establish a probability of success on the right of access to information, counsel, and the courts as asserted in Count Number 8.

I now reach my conclusion.

CONCLUSION

Plaintiffs have failed to establish any of the prerequisites to a grant of preliminary injunctive relief.

They have failed to establish a probability of success on the merits of any of the five claims they assert for preliminary injunction purposes, even under the relaxed standard articulated in Kikumura v. Hurley, 242 F.3d 950, with the relevant discussion at page 955.

Plaintiffs have failed to demonstrate that absent a preliminary injunction they would suffer any non-speculative irreparable harm.

As to the third factor, the balance of the equities does not tip in plaintiffs' favor. Plaintiffs have been successfully prosecuted, convicted, and sentenced to death in proceedings that have withstood decades of trials, direct review, and collateral review. The equities of the matter strongly favor bringing their cases at long last to a [80] conclusion by carrying out the penalty that the courts have determined to have been constitutionally imposed.

Finally, I conclude that entry of a preliminary injunction would not be in the public interest. It is well-settled that as the Supreme Court said in its unanimous decision in Nelson v. Campbell, 541 U.S. 637, with the relevant discussion at page 6844, the

state has "a significant interest in meting out a sentence of death in a timely fashion."

And the Supreme Court also told us in Calderon v. Thompson, 523 U.S. 538, a decision from 1998, at page 556—and here again I'm omitting some citations and internal quotes. "When lengthy federal proceedings have run their course and a mandate denying relief has issued, finality acquires an added moral dimension. Only with an assurance of real finality can the state execute its moral judgment in a case. Only with real finality can the victims of crime move forward knowing the moral judgment will be carried out. To unsettle these expectations is to inflict a profound injury to the powerful and legitimate interest in punishing the guilty, an interest shared by the state and the victims of crime alike."

The motion of Plaintiffs Charles Warner, Richard Glossip, John Grant, and Benjamin Cole for preliminary injunction is without merit. It is in all things denied. A brief written order will be entered to memorialize this ruling.

I direct the parties to withdraw their exhibits. That is [81] routine for purposes of facilitating the parties getting the exhibits to the Tenth Circuit for review. So I do direct the parties to withdraw their exhibits. That is entirely separate from any questions about ultimate public access to the exhibits, which I have already addressed and which I hope the Department of Corrections will itself address very quickly.

Court will be in recess.

(COURT ADJOURNED.)

CERTIFICATE OF OFFICIAL REPORTER

I, Tracy Washbourne, Federal Official Realtime Court Reporter, in and for the United States District Court for the Western District of Oklahoma, do hereby certify that pursuant to Section 753, Title 28, United States Code that the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 23rd day of December 2014.

/S/ Tracy Washbourne

Tracy Washbourne, RDR, CRR
Federal Official Court Reporter

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT

No. 14-6244
(D.C. No. 5:14-CV-00665-F)

CHARLES F. WARNER, BENJAMIN R COLE, by and through his next friend ROBERT S. JACKSON, JOHN M. GRANT, and RICHARD E. GLOSSIP,

Plaintiffs - Appellants,

JAMES A. CODDINGTON, CARLOS CUESTA-RODRIGUEZ, NICHOLAS A. DAVIS, RICHARD S. FAIRCHILD, WENDELL A. GRISSOM, MARLON D. HARMON, RAYMOND E. JOHNSON, EMMANUEL A. LITTLEJOHN, JAMES D. PAVATT, KENDRICK A. SIMPSON, KEVIN R. UNDERWOOD, BRENDA. A ANDREW, SHELTON D. JACKSON, PHILLIP D. HANCOCK, JULIUS D. JONES, ALFRED B. MITCHELL, and TREMANE WOOD,

Plaintiffs,

v.

KEVIN J. GROSS, MICHAEL W. ROACH, STEVE BURRAGE, GENE HAYNES, FRAZIER HENKE, LINDA K. NEAL, EARNEST D. WARE, ROBERT C. PATTON, ANITA K. TRAMMELL, EDWARD EVANS, H-UNIT SECTION CHIEF X, and JOHN DOE EXECUTIONERS #1-10,

Defendants - Appellees.

APPEAL FROM THE
UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Submitted on the briefs:

Patti Palmer Ghezzi and Randy A. Bauman, Assistant Federal Public Defenders, Western District of Oklahoma, Oklahoma City, Oklahoma, and Mark Henricksen and Lanita Henricksen, Henricksen & Henricksen, Oklahoma City, Oklahoma, and Dale A. Baich and Robin C. Konrad, Assistant Federal Public Defenders, Phoenix, Arizona, for Plaintiffs-Appellants.

John D. Hadden, Jeb E. Joseph, and Aaron J. Stewart, Assistant Attorneys General, Oklahoma Attorney General's Office, Oklahoma City, Oklahoma, for Defendants-Appellees.

Before BRISCOE, Chief Judge, GORSUCH and MATHESON, Circuit Judges.

BRISCOE, Chief Judge.

Plaintiffs Charles Warner, Richard Glossip, John Grant, and Benjamin Cole, all Oklahoma state prisoners convicted of first-degree murder and sentenced to death, were among a group of twenty-one Oklahoma death-row inmates who filed this 42 U.S.C. § 1983 lawsuit challenging the constitutionality of the State of Oklahoma's lethal injection protocol. Plaintiffs, facing imminent execution, sought a preliminary injunction to prevent their executions until the district court could rule on the merits of their claims. The district court denied their request. Plaintiffs now appeal. Exercising jurisdiction pursuant to 28 U.S.C. § 1291, we agree with the

district court that plaintiffs have failed to establish a likelihood of success on the merits of their claims. We therefore affirm the decision of the district court.[1]

I

The Plaintiffs

In August 1997, plaintiff Charles Warner anally raped and murdered the eleven-month-old daughter of his girlfriend. Warner was subsequently convicted by a jury of first degree rape and first degree murder. *Warner v. State*, 144 P.3d 838, 856 (Okla. Crim. App. 2006). Warner was sentenced, in accordance with the jury's recommendation, to death for the murder conviction. *Id.*

In January 1997, plaintiff Richard Glossip, who at the time was working as the manager of an Oklahoma City motel, hired another motel employee, Justin Sneed, to kill the owner of the motel. Per Glossip's suggestion, Sneed carried out the murder by beating the owner to death with a baseball bat. Glossip was ultimately convicted by a jury of first degree malice murder and sentenced to death for that conviction. *Glossip v. State*, 157 P.3d 143, 147 (Okla. Crim. App. 2007).

In November 1998, plaintiff John Grant, at the time a prisoner at the Conner Correction Center in Hominy, Oklahoma, murdered a food service supervisor by repeatedly stabbing her with a prison-made shank. Grant was convicted by a jury of first degree malice

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[1] After examining the brief and appellate record, this panel has determined unanimously that oral argument would not materially assist in the determination of this appeal. *See* Fed. R. App. P. 34(a)(2); 10th Cir. R. 34.1(G). The case is, therefore, submitted without oral argument.

murder and sentenced to death. *Grant v. State*, 58 P.3d 783, 788 (Okla. Crim. App. 2002).

In December 2002, plaintiff Benjamin Cole murdered his nine-month-old daughter by pushing her legs towards her head as she lay on her stomach crying. Cole's actions snapped his daughter's spine in half and resulted in a complete tear of her aorta. Cole was subsequently convicted by a jury of first degree murder and sentenced to death. *Cole v. State*, 164 P.3d 1089, 1092 (Okla. Crim. App. 2007).

All four of the plaintiffs have exhausted their state and federal court remedies and the State of Oklahoma has established specific execution dates for each of them. Plaintiff Warner is scheduled to be executed on January 15, 2015. Plaintiff Glossip is scheduled to be executed on January 29, 2015. Plaintiff Grant is scheduled to be executed on February 19, 2015. Plaintiff Cole is scheduled to be executed on March 5, 2015.

The State's Lethal Injection Protocol

For many years, the State of Oklahoma utilized a three-drug lethal injection protocol comprised of sodium thiopental, pancuronium bromide, and potassium chloride. "The first drug, sodium thiopental . . . , is a fast-acting barbiturate sedative that induces a deep, comalike unconsciousness when given in the amounts used for lethal injection." *Baze v. Rees*, 533 U.S. 35, 44 (2008). "The second drug, pancuronium bromide . . . , is a paralytic agent that inhibits all muscular-skeletal movements and, by paralyzing the diaphragm, stops respiration."[2] *Id.* "Potassium

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[2] In recent years, the State of Oklahoma has substituted vecuronium bromide for pancuronium bromide. And, for the executions of the four plaintiffs in this appeal, the State of

chloride, the third drug, interferes with the electrical signals that stimulate the contractions of the heart, inducing cardiac arrest." *Id.*

Since approximately 2010, the State of Oklahoma has been unable to obtain sodium thiopental, either commercially manufactured or compounded, for use in executions. Although the State of Oklahoma was able, for a short time, to obtain and utilize an alternative barbiturate, pentobarbital, during executions, that drug has also become unavailable to the State of Oklahoma for use in its executions. *See Pavatt v. Jones*, 627 F.3d 1336, 1337 (10th Cir. 2010) (addressing challenge to State of Oklahoma's planned use of pentobarbital).

In approximately early 2014, the State of Oklahoma decided to substitute midazolam hydrochloride (midazolam), a sedative in the benzodiazepine family of drugs, for sodium thiopental and pentobarbital. In other words, the State of Oklahoma intended for midazolam to be utilized, as the first drug in its lethal injection protocol, to render an inmate unconscious prior to the injection of the second and third drugs.

The Clayton Lockett Execution

On April 29, 2014, inmate Clayton Lockett was the first Oklahoma state prisoner to be executed using midazolam as part of the lethal injection execution protocol. As described at length in the district court's oral ruling, Lockett's execution, though ultimately successful, was a procedural disaster. The execution team, over the course of nearly an hour, made at least

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Oklahoma has expressed its intent to substitute rocuronium bromide for vecuronium bromide. These substitutions are not at issue in this appeal.

twelve attempts to establish intravenous (IV) access to Lockett's cardiovascular system. The team ultimately believed, incorrectly, that they had successfully established IV access through Lockett's right femoral vein. And the team compounded this error by placing a hemostat on the IV line and covering the IV injection access point with a sheet.

The execution team proceeded to inject Lockett with the three-drug protocol. In doing so, the team declared Lockett to be unconscious following the injection of the midazolam and prior to the injection of the vecuronium bromide and the potassium chloride. Shortly after the injection of part, but not all, of the potassium chloride, however, Lockett began to move and speak. In particular, witnesses heard Lockett say: "This shit is fucking with my mind," "something is wrong," and "The drugs aren't working." ROA, Vol. 3 at 865.

The execution team lifted the sheet and observed a large area of swelling, smaller than a tennis ball but larger than a golf ball, near the IV access point. The execution team determined that the IV had infiltrated, meaning that the IV fluid, rather than entering Lockett's blood stream, had leaked into the tissue surrounding the IV access point. The team stopped administration of the remaining potassium chloride and attempted, unsuccessfully, to insert the IV into Lockett's left femoral vein.

The execution team, after concluding that Lockett had no viable veins left in which to obtain IV access, terminated the execution process approximately 33 minutes after the midazolam was first injected into Lockett. Approximately ten minutes later, Lockett was pronounced dead, even though the execution team

had not injected the intended amount of potassium chloride into Lockett.

A subsequent autopsy determined that there was a concentration of midazolam in the tissue near the IV insertion site in Lockett's right groin area. The autopsy also determined, however, that certain amounts of all three drugs had been distributed throughout Lockett's body, and that the concentration of midazolam in Lockett's blood was greater than the concentration required to render an average person unconscious.

Oklahoma's Revised Execution Procedures

After conducting an investigation into Lockett's execution, the State of Oklahoma adopted a new execution protocol, effective September 30, 2014. As the district court found, the new protocol "is noticeably more detailed" in terms of the "procedures for establishing IV access to the offender's cardiovascular system, the procedure for administering the chemicals, and the procedures for dealing with mishaps or unexpected contingencies." *id.* at 870. In particular, "[t]ne new protocol provides for the insertion of a primary IV catheter and a backup IV catheter," *id.* at 875, and allows for an execution to be postponed if viable IV sites cannot be established within an hour's time, *Id.* at 876. The new protocol "also includes detailed provisions with respect to training and pre-execution preparation of the members of the execution team." *Id.* at 870.

The new protocol gives the Director of Oklahoma's Department of Corrections (DOC) "four alternatives with respect to the combination of drugs to be used in the lethal injection process." *Id.* at 874. The first alternative "calls for the administration of 5,000

milligrams of pentobarbital in a one-drug procedure." *Id.* The second alternative "provides for the administration of 5,000 milligrams of sodium pentothal . . . in a one-drug procedure." *Id.* The third alternative "provides for the administration of 500 milligrams of midazolam and 500 milligrams of hydromorphone." *Id.* The fourth alternative "provides for the administration of 500 milligrams of midazolam, 100 milligrams of vecoronium bromide, and 240 milliequivalents of potassium chloride." *Id.* Under the new protocol, the Director "shall have the sole discretion to determine which chemicals will be used for the scheduled execution." *Id.* "This decision is required to be provided to the offender in writing ten calendar days before the scheduled execution date." *Id.*

It is undisputed that the Director has selected the fourth alternative, i.e., the midazolam/vecoronium bromide/potassium chloride combination, for use in the executions of the four plaintiffs in this case and has notified plaintiffs of that fact.[3]

II

Plaintiffs' Complaint

On June 25, 2014, the four plaintiffs, along with seventeen other Oklahoma inmates sentenced to death, initiated this action by filing a 42 U.S.C. § 1983 complaint against the Director and various other DOC officials. The complaint alleged eight counts. Of relevance to this appeal are Counts 2 and 7.

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[3] In their appellate brief, defendants acknowledge that they only ha[ve] immediate plans to use" the fourth alternative in carrying out lethal injections. Aplee. Br. at 12.

Count 2 challenges, as violative of the Eighth Amendment, the defendants' proposed use of midazolam in Oklahoma's lethal injection protocol. In support, Count 2 alleges that the inherent characteristics of midazolam—including an alleged ceiling effect (i.e., a certain dosage level beyond which incremental increases in dosage would have no corresponding incremental effect) and an alleged risk of paradoxical reactions (such as agitation, involuntary movements, hyperactivity, and combativeness)—render it unsuitable "as a stand-alone anesthetic," ROA, Vol. 1 at 960, and thus poses a substantial risk that an inmate would experience "severe pain, needless suffering, and a lingering death," *id.* at 963. In addition, the plaintiffs allege as part of Count 2 that there is a substantial risk that midazolam will, as exemplified by the Lockett execution, be negligently administered and thus result in an inmate consciously experiencing the painful effects of the second and third drugs utilized in the execution protocol.

Count 7, entitled "Eighth Amendment Experimentation on Captive Human Subjects," alleges that defendants, "[b]y attempting to conduct executions with an ever-changing array of untried drugs of unknown provenance, using untested procedures, . . . are engaging in a program of biological experimentation on captive and unwilling human subjects." *Id.* at 979. Count 7 further alleges that there is no "scientifically sound expectation that these experiments will succeed in producing an execution that does not inflict severe pain, needless suffering, or a lingering death." *Id.* According to Count 7, the defendants "have acted and will act with deliberate indifference to the[se] [identified] risks," and that "[if] the attempted executions of the Plaintiffs are allowed

to proceed, the Plaintiffs . . . will be subjected to cruel and unusual punishment." *Id.* at 980.

Plaintiffs' Motion for Preliminary Injunction

On November 10, 2014, the four plaintiffs in this appeal filed a motion for preliminary injunction. The motion asked the district court to "maintain the status quo by barring Defendants from implementing" the new protocol and executing the four plaintiffs "until this litigation is complete and th[e] Court has had a chance to rule on the merits." *Id.* at 1082. In support, the four plaintiffs alleged, in pertinent part, that they could demonstrate a likelihood of success on Counts 2 and 7 of their complaint.[4]

In December 2014, the district court held a three-day evidentiary hearing on plaintiffs' motion. Plaintiffs presented testimony from ten lay witnesses and four expert witnesses and submitted numerous exhibits. Defendants presented testimony from one expert witness, a DOC official who oversaw the investigation into the Lockett execution, and the medical examiner who performed an autopsy on Lockett's body.

The District Court's Ruling on Plaintiffs' Motion

On December 22, 2014, the district court ruled from the bench and denied plaintiffs' motion for preliminary injunction. In doing so, the district court concluded that plaintiffs failed to establish a likelihood of success on the merits of Counts 2 or 7. The district court also concluded that plaintiffs "failed to establish any of the

[4] The motion also alleged a likelihood of success on the merits of Counts 4, 5 and 6 of the complaint. Those counts are not, however, at issue in this appeal.

[other] prerequisites to a grant of preliminary injunctive relief." ROA, Vol. 3 at 930.

Plaintiffs filed a notice of appeal on December 23, 2014. They have since filed an emergency motion for stay of execution pursuant to Federal Rules of Appellate Procedure 8 and 27.

III

We review a district court's decision to deny a preliminary injunction under a deferential abuse of discretion standard. *Citizens United v. Gessler*, — F.3d —, 2014 WL 6685443 *8 (10th Cir. Nov. 12, 2014). "Under this standard, we examine the district court's legal determinations de novo, and its underlying factual findings for clear error." *Id.* (internal quotation marks omitted). Thus, we will find an abuse of discretion if the district court denied the preliminary injunction on the basis of a clearly erroneous factual finding or an error of law. *Id.*

"A preliminary injunction is an 'extraordinary and drastic remedy.'" *Munaf v. Geren*, 553 U.S. 674, 689 (2008) (quoting 11A C. Wright, A. Miller, & M. Kane, *Federal Practice and Procedure* § 2948, p. 129 (2d ed. 1995)). "A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).[5]

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[5] Plaintiffs argue on appeal that they need only "'raise[] questions going to the merits [of Counts 2 and 7] so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation.'" Aplt. Br. at 33 (quoting *Kikumura v. Hurley*, 242 F.3d 950, 955 (10th Cir. 2001)). We are not persuaded, however,

A motion for stay pending appeal is subject to the exact same standards. In other words, "[i]n ruling on such a request, this court makes the same inquiry as it would when reviewing a district court's grant or denial of a preliminary injunction." *Homans v. City of Albuquerque*, 264 F.3d 1240, 1243 (10th Cir. 2001).

A. Plaintiffs' likelihood of success on the merits of Counts 2 and 7

The district court in this case grounded its denial of plaintiffs' motion for preliminary injunction, in large measure, on its conclusion that plaintiffs failed to establish a likelihood of success on the merits of Counts 2 and 7. On appeal, plaintiffs assert a number of challenges to that conclusion. In addressing those challenges, we begin by outlining the general principles applicable to Counts 2 and 7. We then review the precise basis for the district court's conclusion that plaintiffs failed to establish a likelihood of success on these two counts. Lastly, we shall explain why, in our view, plaintiffs' challenges to the district court's decision lack merit.

1. Applicable constitutional principles

This is far from the first constitutional challenge mounted to a State's proposed method of execution. Consequently, we have several related and well-

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that this relaxed standard is consistent with Supreme Court precedent. Indeed, in *Hill v. McDonough*, 547 U.S. 573, 584 (2006), the Supreme Court emphasized that "inmates seeking time to challenge the manner in which the State plans to execute them must," in pertinent part, establish "a significant possibility of success on the merits."

In any event, we are not persuaded, based upon our review of the record on appeal, that plaintiffs can satisfy the relaxed standard that they urge us to adopt.

established principles upon which we can rely. The first is that capital punishment itself has been held not to violate the Eighth Amendment's prohibition against the infliction of cruel and unusual punishments. *Baze*, 553 U.S. at 47. Second, the Supreme Court "has never invalidated a State's chosen procedure for carrying out a sentence of death as the infliction of cruel and unusual punishment." *Id.* at 48. Third, the Court has recognized "that there must be a means of carrying . . . out" capital punishment and that "[s]ome risk of pain is inherent in any method of execution—no matter how humane—if only from the prospect of error in following the required procedure." *Id.* at 47. Thus, the Court has emphasized, "the Constitution does not demand the avoidance of all risk of pain in carrying out executions." *Id.* More specifically, "because an execution method may result in pain, either by accident or as an inescapable consequence of death, does not establish the sort of 'objectively intolerable risk of harm' that qualifies as cruel and unusual." *Id.*

All of this said, it remains true "that subjecting individuals to a risk of future harm—not simply actually inflicting pain—can qualify as cruel and unusual punishment." *Id.* at 49. "To establish that such exposure violates the Eighth Amendment, however, the conditions presenting the risk must be '*sure or very likely* to cause serious illness and needless suffering,' and give rise to 'sufficiently *imminent* dangers.'"[6] *Id.* at 49-50 (quoting *Helling v. McKinney*,

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[6] These key holdings are found in Chief Justice Roberts' plurality opinion in *Baze*. Although that opinion was joined by only three Justices, it represents the "narrowest grounds" for the judgment in the case, and thus contains the holdings of the Court. *Marks v. United States*, 430 U.S. 188, 193 (1977); *see Chavez v. Florida SP Warden*, 742 F.3d 1267, 1271-1272 n.4 (11th Cir. 2014) (reaching same conclusion); *Dickens v. Brewer*, 631 F.3d

509 U.S. 25, 33, 34-35 (1993)) (emphasis added in *Baze*). In other words, "there must be a 'substantial risk of serious harm,' an 'objectively intolerable risk of harm' that prevents prison officials from pleading that they were 'subjectively blameless for purposes of the Eighth Amendment.'" *Id.* (quoting *Farmer v. Brennan*, 511 U.S. 825, 842, 846, and n.9 (1994)). Finally, the Supreme Court has stated that "[a] stay of execution may not be granted" on the basis of an Eighth Amendment challenge to a State's lethal injection protocol "unless the condemned prisoner establishes that the State's lethal injection protocol creates a demonstrated risk of severe pain" and "that the risk is substantial when compared to the known and available alternatives." *Id.* at 61.

2. The district court's assessment of Counts 2 and 7

With these principles in mind, we turn to Counts 2 and 7 of plaintiffs' complaint and the district court's analysis of them. Count 2 alleges, in essence, that the use of midazolam during a lethal injection procedure presents a substantial risk of serious harm both because of the inherent characteristics of midazolam, including most notably its alleged ceiling effect and its alleged risk of paradoxical reactions, and because of the likelihood that it will be negligently administered by prison officials. Count 7 effectively alleges that defendants, by adopting a revised lethal injection protocol that includes a new drug, i.e., midazolam, and new procedures, lack any reasonable expectation that the revised protocol and procedures will avoid the infliction of severe pain, needless suffering, or a lingering death. And both counts alleged that "[i]t

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1193, 1145-1146 (9th Cir. 2011) (same); *Jackson v. Danberg*, 594 F.3d 210, 222-223 (3d Cir. 2010) (same).

would be feasible" for defendants "to use sodium thiopental in a single-drug formulation to" carry out the executions, ROA, Vol. 1 at 946, and that the use of sodium thiopental "would significantly reduce the substantial risk of severe pain posed by" midazolam, *id.* at 946-947.

In addressing plaintiffs' likelihood of success on these allegations, the district court found that "[t]he 500 milligram dosage of midazolam, as called for in . . . the revised protocol, is many times higher than a normal therapeutic dose of midazolam" and "will result in central nervous system depression as well as respiratory arrest and cardiac arrest." ROA, Vol. 3 at 892. The district court further found that a 500 milligram dosage of midazolam "is highly likely to render the person unconscious and insensate during the remainder of the procedure" and that, "[c]onsequently, analgesia, from midazolam or otherwise, is not necessary." *Id.* at 892-893. In sum, the district court found that "[t]he proper administration of 500 milligrams of midazolam . . would make it a virtual certainty that an individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from application of the second and third drugs" called for by the revised protocol, and that "a 500 milligram dose [of midazolam] alone would be likely to cause death by respiratory arrest within an hour and probably closer to 30 minutes." *Id.* at 893.

The district court, relatedly, made factual findings relevant to plaintiffs' claims that midazolam has a ceiling effect and a risk of paradoxical reactions, either of which, according to plaintiffs, could result in an inmate consciously experiencing the effects of the second and third drugs in the revised protocol. With

respect to the purported ceiling effect, the district court expressly found "persuasive[]" the testimony of defendants' expert witness, Dr. Roswell Lee Evans, the Dean of the School of Pharmacy at Auburn University. *Id.* at 894. As summarized by the district court, Dr. Evans testified that "whatever the ceiling effect of midazolam may be with respect to anesthesia, which takes effect at the spinal cord level, there is no ceiling effect with respect to the ability of a 500 milligram dose of midazolam to effectively paralyze the brain." *Id.* This "phenomenon," according to Dr. Evans, "is not anesthesia but does have the effect of shutting down respiration and eliminating the individual's awareness of pain." *Id.* Thus, the district court essentially rejected plaintiffs' allegation that the 500 milligram dose of midazolam called for in the revised protocol carries a substantial risk

The district court likewise found Dr. Evans' testimony persuasive with respect to the risk of a paradoxical reaction. In particular, the district court found "that with a low therapeutic dose of midazolam there would be less than a 1 percent incidence of a paradoxical reaction." *Id.* at 895. The district court in turn found that "[n]o data [was] available to show what . . . the likelihood of a paradoxical reaction would be with a 500 milligram IV dose of midazolam." *Id.* Thus, the district court found that risk "speculative" at best. *Id.*

As for the likelihood of negligent administration of midazolam, the district court "conclude[d], as a matter of law, that the revised lethal injection protocol adopted by [defendants] is facially constitutional when measured by the principles promulgated in *Baze*." *Id.* at 916 (emphasis added). In doing so, the district court "place[d] considerable reliance . . . on three aspects of

the [revised] lethal injection protocol." *Id.* at 917. These included "the requirement that both primary and backup IV access sites be established," "that confirmation of the viability of the IV sites is specifically required," and "that the offender's level of consciousness must be monitored throughout the procedure." *Id.* The district court in turn "conclude[d] on the basis of the evidence before [it] that plaintiffs ha[d] failed to establish that proceeding with the[ir] execution[s] . . . on the basis of the revised protocol present[ed] a risk that is 'sure or very likely to cause serious illness and needless suffering,' amounting to 'an objectively intolerable risk of harm.'" *Id.* at 916.

As for plaintiffs' allegation that "[i]t would be feasible to use sodium thiopental in a single-drug formulation to" carry out their executions, ROA, Vol. 1 at 946, the district court found this allegation groundless. In particular, the district court noted that "the defendants have affirmatively shown that sodium thiopental and pentobarbital . . . are not available to the DOC." ROA, Vol. 3 at 918. The district court also noted that the defendants' evidence was consistent with the finding in *Pavatt* that "sodium thiopental is now effectively unobtainable anywhere in the United States, thus requiring Oklahoma and other death-penalty states to revise their lethal injection protocols." 627 F.3d at 1338 n.1

As for the allegations of Count 7, the district court found that "[a]s a factual matter, by plaintiffs' own count, execution with midazolam as part of a three-drug-protocol has been accomplished [nationwide] 12 times." ROA, Vol. 3 at 926. Consequently, the district court found "[t]his is not a new method, at least in the sense required for the Court to regard its use as human experimentation." *Id.* The district court also

concluded, as a matter of law, that the plaintiffs failed to "establish that the state's lethal injection protocol creates a demonstrated risk of severe pain and that the risk is substantial when compared to the known and available alternatives." *Id.* at 927.

3. The plaintiffs' challenges to the district court's analysis

In their appeal, plaintiffs mount several challenges to the district court's analysis.[7] As we explain in greater detail below, we conclude that all of these challenges lack merit.

a. The district court's application of Baze

According to plaintiffs, "[t]he district court misapplied *Baze* in four key ways." Aplt. Br. at 37. First, they argue, the district court "decided that [plaintiffs] could not succeed because they failed to present an alternative remedy." *Id.* "Second," plaintiffs argue, the district court "improperly assumed that the grounds asserted in this case were similar to those asserted in *Baze*, therefore skewing the court's risk assessment." *Id.* "Third," plaintiffs argue, the district court "determined that any potential risk was cured by three factors built into the [revised] protocol." *Id.* Lastly, plaintiffs argue that the district court "failed to consider evolving standards of decency in its analysis." *Id.*

The first three of these arguments derive from the undisputed fact that the plaintiffs in this case, unlike the petitioners in *Baze*, are challenging the inherent characteristics of a drug proposed to be used as part

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[7] We note that plaintiffs are not appealing the district court's decision regarding the negligent administration portion of Count 2.

of their lethal injection protocol. In *Baze*, the petitioners asserted only a "risk that the [lethal injection] protocol's terms might not be properly followed" and, to remedy that concern, they "propose[d] an alternative protocol." 553 U.S. at 41. The petitioners in *Baze* conceded that the drugs proposed to be used in their executions, if properly administered, would "result in a humane death." *Id.*

As we have already noted, the Supreme Court in *Baze* held, in addressing the petitioners' claims, that "[a] stay of execution may not be granted on grounds such as those asserted here unless the condemned prisoner establishes that the State's lethal injection protocol creates a demonstrated risk of severe pain." *Id.* at 61. And, the Court further held, "[h]e must show that the risk is substantial when compared to the known and available alternatives." *Id.* Although plaintiffs assert that this latter requirement, i.e., proof of "known and available alternatives," is inapplicable when the challenge at issue concerns the inherent characteristics of a drug proposed to be used as part of the lethal injection protocol, this court previously decided otherwise in *Pavatt*.[8] Like the plaintiffs in this case, the plaintiff in *Pavatt* asserted an Eighth Amendment challenge to a replacement drug (pentobarbital) proposed to be used as part of his lethal injection protocol. Specifically, the plaintiff's expert witness in *Pavatt* "expressed concern that there was insufficient data to allow [the State of Oklahoma] to determine the proper amount of pentobarbital to use as part of its protocol." 627 F.3d at 1340. In addressing this claim, both the district court and this court in *Pavatt* relied on the principles outlined in

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[8] Couriously, plainiffs make no mention of *Pavatt* in either of their appellate briefs.

Baze. In particular, this court expressly noted that, to obtain a stay of execution, the plaintiff would have to establish "'that the risk is substantial when compared to the known and available alternatives.'" *Id.* at 1339 (quoting *Baze*, 553 U.S. at 61). Quite clearly, we are bound by *Pavatt*, "absent superseding en banc review or Supreme Court decisions."[9] *Rezaq v. Nalley*, 677 F.3d 1001, 1012 n.5 (10th Cir. 2012). And, as the district court noted, plaintiffs have not identified any known and available alternatives.

In any event, this second *Baze* requirement is not outcome-determinative in this case because the plaintiffs have failed to establish that the use of midazolam in their executions, either because of its inherent characteristics or its possible negligent administration, creates a demonstrated risk of severe pain. In other words, it is not even necessary in this case to "reach the second step of the *Baze* test." *Raby v. Livingston*, 600 F.3d 552, 560 (5th Cir. 2010).

To the extent that plaintiffs are asserting that the differences in claims renders inapplicable *Baze's* other holdings, including its first requirement for a stay of execution (i.e., the demonstration of a risk of severe pain), we disagree. The constitutional principles

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[9] Even if we were free to decide the issue in the first instance, we would agree with the Eighth Circuit that, even in the context of a challenge to a particular drug proposed to be used as part of a lethal injection protocol, *Baze* requires the plaintiff to establish, in part, the existence of a "known and available alternative." *See In re Lombardi*, 741 F.3d 888, 895-896 (8th Cir. 2014) (concluding, in the context of a challenge to the proposed use of compounded pentobarbital, that *Baze* required the plaintiffs, in the absence of proof that the State purposefully intended to inflict unnecessary pain, to demonstrate a feasible and more humane alternative method of execution).

announced in *Baze*, as we read them, were not confined to claims of negligent administration of lethal injection protocols. Rather, they were intended to apply to all challenges to "a State's chosen procedure for carrying out a sentence of death," 553 U.S. at 48. Thus, we conclude that the district court did not err in applying those principles in assessing plaintiffs' likelihood of success on the merits of Counts 2 and 7.

As for the plaintiffs' third argument, we see no error on the part of the district court in relying on three aspects of the revised lethal injection protocol (i.e., the requirement that both primary and backup IV sites be established, the requirement that the viability of these IV sites are confirmed prior to administration of any drugs, and the requirement that the inmate's level of consciousness be monitored throughout the entire execution procedure). As the district court's oral ruling makes clear, this reliance was not relevant to its rejection of plaintiffs' claims regarding the inherent characteristics of midazolam, but rather to its rejection of plaintiffs' claim of negligent administration. In any event, we see nothing in this aspect of the district court's ruling that is contrary to, or a misapplication of, *Baze*.

That leaves only plaintiffs' argument that the district court violated *Baze* by "fail[ing] to consider evolving standards of decency in its analysis." Aplt. Br. at 37. In support, plaintiffs complain that "Florida is the only other state that has carried out executions using a three-drug protocol with midazolam as the first drug," *id.* at 44, "there have been reports of prisoner movement in Florida," *id.* at 45, and that these facts alone render the defendants' revised lethal injection protocol "objectively intolerable," *id.* Nothing in *Baze*, however, supports these arguments.

To be sure, the protocol at issue in *Baze* enjoyed widespread use at the time of the Supreme Court's decision. But that fact was not critical to, nor was it made a part of, the Supreme Court's key holdings in *Baze*. Indeed, if that were a requirement, it would effectively prevent any state from revising its execution protocol.

b. The district court's reliance on Dr. Evans' testimony

Plaintiffs next argue that the district court abused its discretion by relying on Dr. Evans' testimony and that, in turn, the district court's factual findings that were based on Dr. Evans' testimony were clearly erroneous. We address these arguments in turn.

Plaintiffs begin by asserting that "the district court abused its discretion in relying on Dr. Evans' testimony at all because his opinions are unsupported ipse dixit . . . and based on fundamental errors in his analysis." Aplt. Br. at 46. "Federal Rule of Evidence 702 requires a district court to assess proffered expert testimony to ensure it is both relevant and reliable." *United States v. Avitia-Guillen*, 680 F.3d 1253, 1256 (10th Cir. 2012) (citing *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 589 (1993) (scientific knowledge); *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 141 (1999) (technical and other specialized knowledge)). A district court "generally must first determine whether the expert is qualified by knowledge, skill, experience, training, or education to render an opinion." *Id.* (internal quotation marks omitted). "If the expert is sufficiently qualified, then the court must determine whether the expert's opinion is reliable by assessing the underlying reasoning and methodology." *Id.* (internal quotation marks omitted). "Although a district court has discretion in how it

performs its gatekeeping function, when faced with a party's objection, the court must adequately demonstrate by specific findings on the record that it has performed its duty as gatekeeper." *Id.* (internal quotation marks and brackets omitted).

Generally speaking, we review de novo whether the district court actually performed its gatekeeper role in the first instance and whether it applied the proper standard in admitting expert testimony. *Id.* And, in turn, if the district court performed its gatekeeper role and applied the proper legal standard, we then review for abuse of discretion the district court's decision to admit or exclude the testimony. *Id.* Under this abuse of discretion standard, we will "reverse only if the district court's conclusion is arbitrary, capricious, whimsical or manifestly unreasonable or when we are convinced that the district court made a clear error of judgment or exceeded the bounds of permissible choice in the circumstances." *Id.* (internal quotation marks omitted).

In this case, there is no question that the district court actually performed its gatekeeper role and applied the proper standards in doing so. During its oral ruling on plaintiffs' motion for preliminary injunction, the district court expressly noted that "*Daubert* . . . and *Kumho* . . . establish a gatekeeper function for trial judges under Rule 702 of the Federal Rules of Evidence." ROA, Vol. 3 at 886 (emphasis added). The district court in turn, noting that plaintiffs were challenging "both Dr. Evans' qualifications and his methodology," *id.* at 887, proceeded to outline in detail the *Daubert* and *Kumho* standards, *id.* at 886-889. In our view, the district court considered and applied the correct standards.

We are thus left to determine whether the district court abused its discretion in admitting and in turn relying on Dr. Evans' testimony. As a threshold matter, the district court "reject[ed] plaintiffs' challenge to Dr. Evans' qualifications," noting that "[h]is qualifications go far beyond those of an everyday pharmacist and his clinical experience is an obvious adjunct of his academic attainments." *Id.* at 890. After reviewing Dr. Evans' curriculum vitae and testimony, we conclude that the district court did not abuse its discretion in so ruling. Dr. Evans is the Dean of the Auburn University Harris School of Pharmacy and holds a Pharm.D. from the University of Tennessee. Dr. Evans' academic experience is extensive, having taught as a professor at three different universities over the course of approximately forty years. Dr. Evans has also worked in a variety of clinical pharmacy settings. As the district court aptly noted, Dr. Evans' qualifications are "considerable." *Id.*

The district court then evaluated the reliability of "Dr. Evans' testimony . . . with respect to the risk that a 500 milligram dose of midazolam will fail to induce a state of unconsciousness and his criticisms of the [plaintiffs'] contentions that there is a ceiling effect that is relevant to the determination of whether the prisoner will experience pain after IV administration of 500 milligrams of midazolam." *Id.* at 891. The district court concluded that this "testimony was the product of reliable principles and methods reliably applied to the facts of this case." *Id.* Although plaintiffs point to what they perceive as a number of errors in Dr. Evans' testimony, we conclude these errors were not sufficiently serious to render unreliable Dr. Evans' testimony regarding the likely effect of a 500 milligram dose of midazolam, or to persuade us that the district court's decision to admit Dr. Evans'

testimony amounted to an abuse of discretion. Moreover, we note that plaintiffs do not argue that the district court failed to make adequate *Daubert* findings regarding Dr. Evan's testimony.

That leaves only the plaintiffs' challenge to the district court's factual findings regarding midazolam. After admitting Dr. Evans' testimony, the district court relied on that testimony to make a series of factual findings. To begin with, the district court found that "[t]he 500 milligram dosage of midazolam . . . is many times higher than a normal therapeutic dose of midazolam" and "will result in central nervous system depression as well as respiratory arrest and cardiac [ar]rest." *Id.* at 892. In turn, the district court found that a 500 milligram dosage of midazolam "is highly likely to render the person unconscious and insensate during the remainder of the [lethal injection] procedure" and that, "[c]onsequently, analgesia, from midazolam or otherwise, is not necessary." *Id.* at 893-893. In sum, the district court found that "[t]he proper administration of 500 milligrams of midazolam . . . would make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur . . . from the administration of the second and third drugs . . . , assuming that proper intravenous access has been established." *Id.* at 893. The district court also found that, "because midazolam is water soluble" and "crosses the blood brain barrier very quickly," "[t]he administration of a 500 milligram dose alone would be likely to cause death by respiratory arrest within an hour and probably closer to 30 minutes." *Id.*

The district court also relied on Dr. Evans' testimony to rebut plaintiffs' claims that midazolam has both a ceiling effect and a risk of paradoxical

effects. With respect to the alleged ceiling effect, the district court found that "Dr. Evans testified persuasively, in substance, that whatever the ceiling effect of midazolam may be with respect to anesthesia, which takes effect at the spinal cord level, there is no ceiling effect with respect to the ability of a 500 milligram dose of midazolam to effectively paralyze the brain, a phenomenon which is not anesthesia but does have the effect of shutting down the individual's awareness of pain." *Id.* at 894. In addition, the district court found that "[t]he dosage at which the ceiling effect may occur at the spinal cord level is unknown because no testing to ascertain the level at which the ceiling effect occurs has been documented." *Id.* As for paradoxical effects, the district court acknowledged that, according to midazolam's product label, "[t]he use of midazolam presents a risk of paradoxical reactions or side effects such as agitation, involuntary movements, hyperactivity, and combativeness." *Id.* at 894-895. The district court found that "[t]he likelihood that a paradoxical reaction will occur in any particular instance is speculative, but . . . occurs with the highest frequency in low therapeutic doses." *Id.* at 895. Even then, the district court found, "there would be less than a 1 percent incidence of a paradoxical reaction." *Id.* And, the district court noted, "[n]o data are available to show what . . . the likelihood of a paradoxical reaction would be with a 500 milligram IV dose of midazolam." *Id.* Ultimately, the district court found that "[t]he evidence falls well short of establishing that the risk of a paradoxical reaction at a 500 milligram IV dosage presents anything more than a mere possibility in any given instance that midazolam will fail to deliver its intended effect." *Id.*

After carefully examining the record on appeal, we are unable to say that any of these factual findings are

clearly erroneous. To be sure, plaintiffs' counsel, in cross-examining Dr. Evans, focused on what appear to have been certain errors in his testimony. These include Dr. Evans' misidentification of the reported toxic dose range of midazolam (i.e., the dose range at which deaths have actually occurred from midazolam in a clinical setting), his assertion that Material Safety Data Sheets are mandated by the Federal Drug Administration rather than the Occupational Safety and Health Administration, and his testimony that midazolam inhibits gamma aminobutyric acid (GABA). We are not persuaded, however, that any of this seriously undercuts the key portions of Dr. Evans' testimony that were relied on by the district court. As Dr. Evans noted both in his report and in court, the 500 milligram dose of midazolam called for in defendants' revised lethal injection protocol is at least 100 times the normal therapeutic IV dose and, if properly administered, will render a person unconscious and insensate during the remainder of the lethal injection procedure.

c. The district court's conclusions regarding Count 7

Plaintiffs contend the district court erred in analyzing Count 7 because it "applied its interpretation of the risk-analysis test in *Baze*" instead of "applying the 'evolving standards of decency' analysis." Aplt. Br. at 57. We have already considered and rejected a similar, if not identical, argument above. In any event, we reject plaintiffs' assertion that Count 7 is not subject to the principles or mode of analysis outlined in *Baze*.

d. Summary

We ultimately conclude, having rejected plaintiffs' various challenges to the district court's analysis of Counts 2 and 7, that the district court correctly determined that plaintiffs failed to establish a significant possibility of success on the merits of Counts 2 or 7.

B. The remaining three requirements for preliminary injunction

As part of their appeal, plaintiffs also argue that "[t]he district court erred when it concluded [they] could not demonstrate the other three requirements for a preliminary injunction." Aplt. Br. at 62. Having concluded, however, that plaintiffs failed to establish a significant possibility of success on the merits of Counts 2 or 7, we find it unnecessary to address the remaining requirements for a preliminary injunction.

C. Emergency motion for stay of execution

As we have noted, the standards for granting a motion for a stay pending appeal, or more precisely in this context a stay of the plaintiffs' executions, are identical to those for granting a preliminary injunction. Having concluded that plaintiffs failed to establish a significant possibility of success on the merits of Counts 2 or 7, we therefore deny their emergency motion for stay of execution pending appeal.

IV

The district court's order denying a preliminary injunction is AFFIRMED.[10] Plaintiffs' emergency motion for a stay of execution pending appeal is DENIED.

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[10] In an abundance of caution, this opinion was circulated to all active judges of this court prior to publication. No judge requested a poll on the questions presented by plaintiffs. Thus, no *en banc* consideration is warranted or available.

140

(ORDER LIST: 574 U.S.)

14-7955
(14A796)

GLOSSIP, RICHARD E., ET AL.

v.

GROSS, KEVIN J., ET AL.

WEDNESDAY, JANUARY 28, 2015

ORDER IN PENDING CASE

Respondents' application for stays of execution of sentences of death presented to Justice Sotomayor and by her referred to the Court is granted and it is hereby ordered that petitioners' executions using midazolam are stayed pending final disposition of this case.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-655-F

CHARLES F. WARNER, ET AL.,

Plaintiffs,

vs.

KEVIN J. GROSS, ET AL.,

Defendants.

TRANSCRIPT OF PRELIMINARY INJUNCTION
HEARING BEFORE THE HONORABLE
STEPHEN P. FRIOT UNITED STATES
DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

* * * *

[283] THE COURT: We'll have the plaintiffs' next witness.

MS. GHEZZI: Your Honor, we decided to change up the witnesses a little bit. The two witnesses that we have that will be brief are ODOC witnesses and they're out in the hall, so we'll go ahead and call them first.

THE COURT: Very well.

MS. GHEZZI: Mike Oakley.

MICHAEL OAKLEY,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MS. GHEZZI:

Q. Would you state and spell your name, please.

A. My name is Mike—Michael Oakley. M-I-C-H-A-E-L, Oakley, O-A-K-L-E-Y.

Q. And, Mr. Oakley, what was your employment at the time of—oh, in the time period of March 2014?

A. In March of 2014, I was employed with the Department of Corrections.

Q. And what was your position there?

[284] A. I was the general counsel.

Q. And had you announced retirement during that period?

A. Yes, I had announced retirement, I believe, in February.

Q. And when was your retirement date?

A. My last day of work was the 23rd of April.

Q. So you were not on board at ODOC at the time of the scheduled executions for Clayton Lockett and Charles Warner?

A. No.

Q. Now, what involvement, if any, did you have in the—what we'll call "secrecy litigation" involving Mr. Warner and Lockett early in the case?

A. And when you say "secrecy litigation," please explain—

Q. Okay. I'm sorry. The state litigation that was—

A. In state court?

Q. State court litigation.

A. I was the contact person for that, but the Attorney General's Office was litigating that.

Q. And as the contact person, what, if any, involvement did you have in keeping track of what was going on in that litigation to inform the director?

A. Well, I get the pleadings and certainly have conversations with the—with counsel from time to time when there are developments.

Q. Now, prior to your testimony today, did you, in fact, look back at some of the documents that related to that secrecy [285] litigation?

A. I did.

Q. And what was your purpose in looking at those documents?

A. I was trying to familiarize myself with the dates. It has been quite some time and I wasn't really remembering the dates.

Q. I'd like to show you Plaintiffs' Exhibit 15 at page 863 and 864.

A. Fifteen?

Q. Yeah. And see the Bates stamp there at the bottom, 863?

A. Yes.

Q. And that full paragraph at the end there, beginning with "ODOC."

A. Yes.

Q. And "ODOC" refers to what?

A. The Oklahoma Department of Corrections.

Q. And you see that they have—is that a pleading that was filed regarding the stay?

A. I believe—I have to look at the very beginning of it, but I believe this was a pleading that was filed by the state, yes. It appears to be, yes.

Q. And it's where they were notifying the Court of Criminal Appeals about the status of drugs related to the Lockett and Warner executions?

A. Yes.

Q. Were you aware of difficulties by the department in [286] obtaining the drugs that were—the drugs that—under the old protocol for the March executions?

A. Yes. Pentobarbital, yes.

Q. And this says, "By Friday, March 14th, the commitment fell through and as of Monday, March 17th"—and then if you'll go to the next page—or I'm sorry, go down further—"that ODOC remains without drugs needed to carry out the lawful sentences of death for Lockett and Warner."

A. Yes.

Q. And was that your understanding on March 17th that that was—

A. Yes. I don't recall it myself, but—the date myself. I remember it existing. If the pleading says that, I guess that's when it was.

Q. Now, what involvement do you have in the development or the writing or drafting of new protocols?

A. Well, the protocol itself is—at that time, was a field memorandum kept at Oklahoma State

Penitentiary. The Attorney General's Office—the litigation that surrounded the protocol caused us to consult the Attorney General's Office quite often. So we would consult with them and I would ask for a Word document, because it was kept in PDF form, and whenever it was going to be changed, I would have it sent to me, we would draft the—I would draft the changes and submit it to the Attorney General's Office and see what their thoughts were.

[287] Q. And when you determine in March or the ODOC determines in March that there's difficulty obtaining these drugs, was a decision made to change the drug portion of the protocol?

A. Yes.

Q. Who made that decision?

A. Well, there were a number of people involved in that decision. We consulted with the Attorney General's Office. The director was involved in that decision, obviously. I was involved in that decision. We knew that there were other drugs that had been used in other states successfully. And so we—the reason we decided on midazolam was because it had been used effectively and we knew that we had testimony from others—from sources that—I'm having—I'm taking it slowly because I don't want to cross the line into attorney/client privilege. But I will say generally that we knew midazolam had the same properties as pentobarbital as far as sedation goes.

Q. And that determination of the properties of midazolam, did that come from attorneys general or other DOC personnel in other states?

MR. HADDEN: Again, Your Honor, I'm going to object on the basis of attorney/client privilege. The

substance of communications and who provided what communications and (inaudible)—

COURTROOM DEPUTY: Speak into the microphone, please.

MR. HADDEN: General objection on the substance of [288] communications between counsel, not necessarily on whether different counsel were consulted or not.

THE COURT: The question goes only to the source of information known to the witness. That's permissible. That objection will be overruled. Again, obviously, Ms. Ghezzi, it's necessary to craft your questions very carefully. And I trust that you will do so. But that objection will be overruled.

THE WITNESS: Would you repeat the question, please?

THE COURT: The question is—hold on just a second. The question is whether your information about the properties of midazolam came from attorneys general or other DOC personnel in other states.

THE WITNESS: Came from both actually, yes.

Q. (BY MS. GHEZZI) And did you do any specific research yourself?

A. I did.

Q. And where did you do that research?

A. I started with the Internet. Most times I don't go to the library these days, I go to the Internet. And so there are—were several what I consider to be reliable sources on the properties of pharmaceuticals and I compared several different sites and got the same results about the properties for midazolam for

sedation purposes. The first drug, obviously, was for sedation purposes only, so that's what I was looking [289] for, those kinds of properties.

Q. Now, these sites that you went to, do you know anything about whether there has been any criticism in the pharmaceutical area or arena over the quality of the information provided in those specific—

A. I'm not aware of any.

Q. Now, there was some—was there any pressure to get a protocol with a new drug in place before the executions that ultimately got set April 22nd and 29th and then combined on the 29th?

A. Yes. The litigation was such that I understand that—I wasn't there at any of the meetings, but I understand that our attorneys, the Attorney General's Office, had offered the final protocol at a particular time. I wasn't aware of exactly when. But, yes, there was pressure to get it done by that particular time because of the litigation. As in this litigation, there's always a deadline. And, yes, it was—there was pressure.

Q. And was this—

THE COURT: Excuse me. Are you talking about time pressure or pressure exerted by people walking into your office and telling you that you had to do something?

THE WITNESS: Sir, both. There was pressure from—yes, there was pressure from those people who were above us to get it done and get it in place.

Q. (BY MS. GHEZZI) And when you say those above us, that's [290] really referring to political pressure?

A. There was—there was—there were calls from the Governor's Office. There were meetings at the Attorney General's Office that I was not—I didn't attend them. But after those meetings, we would get word from the Attorney General's Office that we better hurry up and do something. And especially with this one date on a Friday of spring break, when you were supposed to be furnished the final protocol. And, you know, there's—in this litigation were supposed to be furnished the final protocol, yes, there was pressure.

Q. And so, actually, the final protocol was signed by the warden on March 21st, do you know?

A. I don't know.

Q. Let me show you Plaintiffs' Exhibit 3. And just the cover page of that. I think—don't those field memorandums have the effective date at the top of them, Mr. Oakley?

A. Yes, they used to. It says, "effective date 3/21/14." That's the effective date. I don't know when she would have signed it. I know that she was out of the office on the date that I mentioned on that Friday. So she probably—she might have signed it on the same day, but that's the effective day.

Q. Now, so essentially, between the time of Friday, March 14th, when it's clear that these drugs that you had used in the past are difficult to find and then by March 21st the midazolam protocol is in effect?

[291] A. Yes.

Q. And you may not remember this, but do you remember specifically what pharmaceutical or pharmacy sites that you went to on the Internet for your own research?

A. I don't remember. There are a number of them that I checked. And I didn't see any negative effects for our purposes. You know, and I certainly didn't see anything by any experts that would indicate that it wouldn't do exactly what we needed it to be done.

Q. Did you hear anything or did you review anything on the Internet that dealt with the issue of midazolam having what's called a "ceiling effect"?

A. No.

Q. Did you review anything on the Internet that advised regarding midazolam's properties that in some populations, particularly vulnerable populations, cause a paradoxical effect?

A. I'm not aware of that.

Q. And did you—do you have any pharmaceutical background or medical background?

A. No, I don't.

Q. Who picked the dosage of midazolam?

A. We consulted with the protocol that was used in Florida and that dosage was—and it had been used successfully and that dosage was utilized.

* * * *

[297] Q. You were also asked some questions about specific research. The answers that you're giving, was that just related to research you personally did?

A. That was just related to my research only, yes.

Q. Did you have access, though, to other forms of research?

A. Well, yes.

Q. As an example, would you also have access to transcripts of experts from across the country in various death penalty litigation?

A. Yes.

Q. Would that include experts of death row inmates?

A. Yes.

Q. Do you specifically recall reading or referring to any of those at any time?

A. Yes. We—we looked at the cases—cases in other states. And I believe Florida was one of those states.

Q. Based upon the overall research that was conducted that was received from various sources, did you feel confident that the drugs and the amounts of the drugs in the protocols were constitutionally adequate?

A. Yes. They would not have been put in otherwise.

Q. And do you also have an expectation if you develop a protocol and it is insufficient that it will at least be brought to your attention by the attorneys for the inmates who may be subject to it?

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-655-F

CHARLES F. WARNER, ET AL.,

Plaintiffs,

vs.

KEVIN J. GROSS, ET AL.,

Defendants.

TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING BEFORE THE HONORABLE STEPHEN P. FRIOT UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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* * * *

[89] DIRECT EXAMINATION

BY MS. GHEZZI:

Q. Would you state and spell your name.

A. My name is Anita Trammell. A-N-I-T-A, T-R-A-M-M-E-L-L.

Q. And, Ms. Trammell, what's your occupation or profession?

A. I'm the warden at OSP, Oklahoma State Penitentiary.

Q. And would you just describe briefly for the Judge how the penitentiary is set up as it relates to H-Unit, where the execution chamber is, and where offenders with death sentences are held?

A. H-Unit has four housing units. The death row, as we refer to it, is on southwest. The execution chamber is upstairs. And you can—there's a door that goes to southwest.

Q. And the H-Unit building itself is separate from the administration offices and the large older building that is sometimes referred to as "the walls"; is that correct?

A. Yes.

Q. How long have you been the warden at OSP?

A. Since September 2012.

Q. And as the warden, have you had responsibilities for executions during that time?

A. Yes.

Q. And how many executions?

A. I have witnessed 11. I have observed two.

Q. And were the first two that—the ones that you observed, [90] were those the first two that you—

A. Yes.

Q. —observed? And who in April—in April of this year, who was responsible for the execution protocol that was used for Mr. Lockett?

A. I was.

Q. And did you draft and prepare that protocol?

A. No.

Q. Do you know who did?

A. No.

Q. And did you sign it?

A. Yes.

Q. And who provided it to you to sign?

A. Mike Oakley, who was our general counsel at the time.

Q. And by "general counsel," he was general counsel of the Oklahoma Department of Corrections at the time; is that correct?

A. Yes.

Q. And was that done initially in March, March 21, 2014, if you recall?

A. I don't recall the exact date.

Q. Now, in the executions that you had observed prior to Mr. Lockett's execution, do you know what drug was used for the purpose of rendering the offender unconscious and insensate to pain?

[91] A. Yes.

Q. And what was that drug?

A. Pentobarbital.

Q. And did you also know what changes, if any, were being made to the protocol regarding the drug pentobarbital?

A. Yes. I did know, yes.

Q. And from whom did you know that information?

A. I would say it was Mike Oakley, as well as reading it in the policy.

Q. And did you know anything about the drug midazolam?

A. No, I didn't.

Q. And did you do any independent research yourself about the drug midazolam?

A. No.

Q. Did you rely exclusively on what other people were telling you about that drug?

A. Yes.

Q. And who did you receive information about the drug midazolam from besides Mr. Oakley?

A. The director and I had a conversation about midazolam.

Q. And would that conversation with the director have occurred on the same day of Clayton Lockett's execution?

A. Yes.

Q. And in that conversation, was it your understanding that the director had had some personal experience with the drug

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9:00 A.M.

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* * * *

[459] BY MR. BAICH:

Q. Good afternoon, Mr. Patton.

A. Good afternoon, sir.

Q. Could you please state your name and spell it for the record.

A. Robert Patton. R-O-B-E-R-T, P-A-T-T-O-N.

Q. And can you tell me your current position?

A. I'm currently the director of the Oklahoma Department of Corrections.

Q. And prior to your appointment as the director of the Oklahoma Department of Corrections, what position did you hold?

A. Immediately prior to my appointment?

Q. Yes.

A. I was the division director of operations for the Arizona Department of Corrections.

Q. And as the division director in Arizona, did you have any responsibilities related to executions?

A. I did.

Q. And can you tell me what they were?

A. I was responsible for the overall operation of executions.

Q. And what does that mean?

A. If you have the Arizona protocol, I'll be happy to read. There was probably 75, 80 things I had to do.

Q. Based on your recollection, what were your responsibilities?

* * * *

[509] discuss it with Scott Crow, yes.

Q. And anyone else at the DOC?

A. The specifics of the Florida protocol, outside of counsel and Scott Crow, I do not believe so, sir.

Q. Okay. You have heard information presented during this hearing—testimony presented during this hearing that midazolam has no analgesic properties;

did you hear that testimony from Dr. Sasich and Lubarsky?

A. I did hear their testimony, sir.

Q. Knowing that information, are you satisfied that midazolam is a reliable drug that would produce a level of unconsciousness that would likely prevent the plaintiffs from experiencing the pain and suffering from the administration of the drugs?

A. I am not a medical expert, sir, but according to the medical expert that will testify this afternoon, I am confident.

Q. Did you consult with Dr. Evans?

A. The Attorney General's Office did, sir.

Q. But you had no direct conversations with Dr. Evans?

A. I have not had direct conversations with Dr. Evans.

Q. So the Attorney General's Office is between you and the expert?

A. That is a fair statement.

Q. So the information that you get is not from a medical [510] expert, but from your attorneys?

MR. JOSEPH: Objection, Your Honor.

THE COURT: Overruled.

THE WITNESS: I have not had direct conversations with Dr. Evans, sir.

Q. (BY MR. BAICH) Okay. You have heard testimony presented during this hearing that midazolam has a ceiling effect and, therefore, large

doses of the drug does not mean it's more effective. Did you hear that testimony?

A. I have heard that testimony.

Q. Okay. Knowing that information, are you satisfied that midazolam is a reliable drug that would produce a level of unconsciousness that would likely prevent the plaintiffs from experiencing the pain and suffering from the administration of the drug?

A. And I will continue to answer that question, as briefed by the Attorney General's Office: Yes.

Q. And one more question for the record. Please, bear with me.

Midazolam can result in paradoxical reactions, particularly in certain populations, including those with a history of aggressive or impulsive behavior, alcohol abuse or psychiatric disorders.

Knowing that information, are you satisfied that midazolam is a reliable drug that would produce a level of [511] unconsciousness that would likely prevent plaintiffs from experiencing the pain and suffering from the administration of the drug?

A. And I rely on my previous answer to that question, sir.

Q. Are you familiar with the Joe Wood execution that took place in Arizona in July of 2014?

A. Through the same media reports everybody else is familiar with it, sir.

Q. But you had no conversations with your former director or anyone else at the Arizona Department of Corrections about that execution?

A. Not specifics to that execution. Of course, I called him the next day after the media reports to see if he was doing okay.

Q. And by "him" you're referring—

THE COURT: To do what?

THE WITNESS: To see if he was doing okay. I'm sorry, Your Honor.

Q. (BY MR. BAICH) And by "him," you mean Director Ryan?

A. Correct.

Q. Are you familiar that midazolam was used during the execution of Joseph Wood?

A. I'm aware that midazolam and hydromorphone were the two drugs used in Joseph Wood's execution.

Q. And are you aware that it took almost two hours for [512] Mr. Wood to—to die?

A. Through the media reports, yes, sir, I'm aware of that.

Q. But not from Director Ryan or anyone else at the Arizona Department of Corrections?

A. I'm not going to say Director Ryan didn't say it was two hours, but I'm more familiar with the case through the media reports, sir.

Q. What is your basis for picking 500 milligrams of midazolam and hydromorphone as an option under your protocol here in Oklahoma, knowing that Mr. Wood lingered almost two hours before dying?

A. Chart D requires 500 milligrams, so I stuck with the Chart D when developing. I believe now you're talking about Chart C, sir?

Q. Yes, I am.

A. 500 milligrams is used in Chart D, so I stuck with the 500 milligrams and matched that with hydromorphone and sent for review to our medical expert.

Q. And are you aware that Mr. Wood was administered 750 milligrams of midazolam?

A. I am, sir.

Q. I'd now like to take a few minutes to go through the protocol with you, Exhibit 68. And we'll start at page 6, under B, the H-Unit.

Can you tell me if you have selected the H-Unit Section [513] Chief?

A. I have.

Q. Okay. Is that person—does that person have any medical training?

A. Can you please define that?

Q. Well, under the—under your protocol, the H-Unit Section Chief is to monitor the prisoner—or monitor the line into the prisoner and requires that the person doing the monitoring have medical training.

So I'm asking if the H-Unit Section Chief has medical training.

A. The H-Unit Section Chief has informal training as to what to look for for a line that may or may not fail. And then 24 hour prior, when the IV Team comes in, he'll receive training from them, as well as to what to look for in the IV line, sir.

Q. Okay. Now I'd like to move on to page 7, under C, the IV Team.

And can you tell me if an execution in Oklahoma can be carried out without a physician being present?

A. It can.

Q. And can you tell me if you have selected the IV Team for the four scheduled executions?

A. I have.

Q. Can you tell me if a member—if a physician is a member of that team?

[514] A. A physician has been selected as the IV Team leader.

Q. Can you tell me if a physician assistant has been selected as a member of the IV Team?

A. I can tell you that the second IV Team person, that the IV Team member is a paramedic.

Q. Can you tell me if the physician that—strike that.

I'd like to have you look at C(1)(f), military corpsman or other certified or licensed personnel, including those trained in the United States military.

I know what a "military corpsman" is, but I'm not sure what a "certified or licensed personnel"—I'm not sure of the definition of that. Can you explain them to me?

A. The military has several different job descriptors and we didn't list them all in there, as far as their medically trained staff. So were they licensed medically by the United States military, is that what—that's what (f) means.

Q. So—just so I'm clear, under (f), the person would be in the military?

A. That is correct.

Q. And there would be some licensing that the military—

A. Certification by the military. I don't know if "licensing" is the best word to use, but certified by military.

THE COURT: Let me interrupt for going back about a minute and a half just for a follow-up question.

[515] Director Patton, you said that for the four upcoming executions a physician has been selected as the IV Team leader. If all goes as planned, during the administration of the drugs, where will the physician be situated?

THE WITNESS: Your Honor, the physician is inside what is now called the "operations room." He'll be—he or she shall be standing by the two monitors that are on the wall and the ECG machine.

THE COURT: And those are the monitors that pick up the—or get a feed from the two cameras in the actual execution room?

THE WITNESS: That is correct, Your Honor.

THE COURT: And on that subject, I do—I would like to clarify one thing.

Yesterday, one witness said that those two cameras can tilt and swing, I think. Another witness said that they can zoom. Can they tilt and swing and zoom?

THE WITNESS: They are pan, which goes this way (demonstrating), Your Honor, tilt, that goes this way (demonstrating), and then zoom into the site. So there's three controls to the camera.

THE COURT: And do you anticipate that the physician would have—or at least would be expected to view the IV access sites in that way?

THE WITNESS: The intention of the dual camera, sir, [516] is one of the cameras zooms in into the IV site that you are using at the time. Let's say it's the primary, it's the right arm. We will zoom that camera into the IV site so the physician can observe the drugs being administered into the primary site.

The other one, it's depending on the physician's preference. It can be taken so he can observe the inmate's reactions to his face or he can take it, if he prefers, and zoom it on the secondary site.

THE COURT: And do any of those chemicals have any color to them?

THE WITNESS: I do not believe so, sir. I believe they're all clear.

THE COURT: Okay. Forgive the interruption. Mr. Baich, you may proceed.

MR. BAICH: Sure.

Q. (BY MR. BAICH) Under Number 3, C(3), the team leader and members are selected by you and a review of the qualifications, training, experience, licensing takes place. Can you tell me what process is used to do that?

A. Yes, sir.

I personally interviewed the team leader. I'm scheduled to interview the team member next week. I talked to the team leader regarding his or her qualifications, their willingness to participate, and was satisfied that they were well-qualified

* * * *

[550] A. I do, sir.

Q. Okay.

THE COURT: Before you go on, let me ask one more question.

MR. JOSEPH: Sure, Your Honor.

THE COURT: If either pentobarbital or sodium thiopental were, in fact, available to the DOC for this purpose, what impact, if any, would that have on your selection of which chart to use? Would that change your–

THE WITNESS: Your Honor, if either of those drugs were available, I would have selected them first.

THE COURT: Very well. Next question.

MR. JOSEPH: Thank you, Your Honor.

Q. (BY MR. JOSEPH) You were questioned on direct about selection of team heads, team members, for the execution protocol. Do you remember that line of questioning?

A. I do, sir.

Q. Okay. And what is your understanding about your role in the protocol with regards to selection of team members and team heads?

A. It varies, depending on which team you're talking about, but, overall, every team member I review their selection. That—teams are broken down, you know, so specifically. The Traffic Control Team, I don't personally go out and pick those

* * * *

[554] Q. Okay. Are you aware that the patent for sodium pentothal has expired?

A. I have no knowledge of that, sir.

Q. What, if any, efforts have you made to inquire whether Oklahoma laboratories could create sodium thiopental?

A. We talked to numerous pharmacies in Oklahoma to try to attempt to get pentobarbital and thiopental and was unable to do so, as I testified earlier, sir.

Q. So you were attempting to get manufactured chemicals?

A. We also talked to some compound pharmacists who could not provide it.

Q. As to both—okay.

You mentioned the training of IV Team members 24 hours before the scheduled execution?

A. Within 24 hours, yes, sir.

Q. Within 24 hours.

Is this training protocol in written form?

A. I'm not sure what your question is.

Q. Well, the scenario that we talked about, simulating what went wrong in Lockett, is that in written form?

A. No. It will be after the training, as the recorder does for all the training notes.

MR. BAICH: Thank you. No further questions.

THE COURT: Any recross?

MR. JOSEPH: Nothing further, Your Honor.

* * * *

[605] You may step down.

THE WITNESS: Thank you, sir.

MR. HADDEN: Defendants call Dr. Joni McClain.

THE COURT: Well, let me make sure. This completes the plaintiffs' presentation of testimony?

MS. GHEZZI: Your Honor, we'd like to recall Director Patton for one question.

THE COURT: He's fair game. Come on up, Director Patton.

MR. JOSEPH: Your Honor, I believe Mr. Baich was doing—I believe Mr. Baich had begun the questioning of this witness.

THE COURT: Well, he may not have the one question in his head. And so with the understanding that it's one question, which is—it hardly ever is one question, but with the understanding that it's something on that order, I'm going to permit Ms. Ghezzi to proceed.

ROBERT PATTON,

(WITNESS PREVIOUSLY SWORN.)

DIRECT EXAMINATION

BY MS. GHEZZI:

Q. Director Patton, when you were testifying for Mr. Baich regarding whether or not the patent for sodium thiopental had expired, the question I'm asking you is: Have you done—made any efforts to determine whether, through OU's medical schools [606] or teaching hospitals or laboratories of the state,

that there are any efforts to determine whether or not those laboratories can produce sodium thiopental?

A. And as I stated, and my answer remains the same, we contacted several pharmacies and compounding pharmacies and were unable to obtain it. I'm not saying that they can't produce it. I'm telling you we cannot obtain it.

Q. Okay. I'm not asking you whether you can obtain it or anything about pharmacies. I'm talking about inquiring of laboratories about making it, not pharmacies.

A. And my answer remains the same: We could find no one that was willing to produce it for us.

Q. Have you made any efforts to contact the University Hospital—

A. I believe I've already answered this question. We've attempted enough times.

THE COURT: Let her finish the question first. Go ahead.

Q. (BY MS. GHEZZI) Have you made any efforts to contact a teaching hospital, a medical hospital, any state laboratory, separate from any kind of pharmacy, over producing the drug sodium thiopental which no longer has a patent?

A. I can answer the question that I have not—I have not personally. I cannot answer a question whether anyone else has. I don't know.

EXPERT REPORT OF DAVID A. LUBARSKY, M.D., MBA

RE: *Charles F. Warner, et. al., v. Gross, et. al.*, No. CIV-14-665F

November 26, 2014

Expert Report of David A. Lubarsky, M.D., MBA
Dated November 26, 2014

Background

1. I am a licensed physician, and I currently serve as the Emanuel M. Papper Professor of Anesthesiology and the Chair of the Department of Anesthesiology at the University of Miami Miller School of Medicine. I have served as Chair for the past thirteen years. I am also the Chief Medical Officer of the University of Miami Health System.

2. In addition to my current position, my experience as an anesthesiologist includes service as the Vice-Chair of the Department of Anesthesiology at Duke University Medical Center from July 1988 to November of 2001. I am licensed to practice medicine in Florida. I am Board Certified in anesthesiology by the American Board of Anesthesiology, and in pain management by the American Academy of Pain Management. I have conducted research and published peer-reviewed articles on the suitability of various drugs as anesthetics and how to adequately maintain anesthetic depth in a clinical setting. I have been a recurring author of the chapter on intravenous induction agents in our specialty's primary authoritative textbook (Miller's Anesthesia).

3. I have conducted research and published almost 100 peer-reviewed articles and many other non-peer-reviewed treatises. Some of these publications deal with the suitability of various drugs as anesthetics and how to adequately maintain anesthetic depth in a clinical setting. I have also published peer-reviewed articles on lethal injection, including the only scientific paper that evaluated available medical data, and have served as an expert witness in lethal-injection litigation in several states, including in Alabama in the case of *Arthur v. Thomas,* 674 F3d 1257 (11th Cir. 2012). I have also served as an expert witness in cases involving lethal injection in Ohio, Tennessee, and Florida. A current copy of my complete CV is attached as Exhibit 1 to this Report. In the previous four years, I have testified as an expert at trial or by deposition in the following cases: *Juan Carlos Chavez, Plaintiff v. John Palmer, etc. et al., Defendants,* Case No. 3:14-cv-110-J-39JBT, in the United States District Court, Middle District of Florida; *State of Florida v. Howell,* Case No. 1992-CF-22; in the Circuit Court for Jefferson County, Florida; *Liptak, Carly v. Rudolph / Dickinson / Anesthesia Associates of Pinellas County, P.A.,* Case No. 12-5386CI-21, in the Circuit Court for Pinellas County, Florida; and in Preliminary Injunction hearing for Ronald Ray Post in In re: *Ohio Execution Protocol Litigation,* Case No. 2:11-cv-1016 (S.D. Ohio), in the United States District Court, Northern Ohio District.

4. I have been retained by counsel for Plaintiffs in *Warner v. Gross,* No. 5:14-cv-00665-F. I was asked to review documents and provide my opinion regarding the use of midazolam generally and

specifically in Oklahoma's lethal-injection execution protocol.

5. I am being compensated for my work in this case at $600 per hour. To date, I have billed the Plaintiffs $2700.

6. I have reviewed the following documents:

Record	Bates Numbers
Autopsy Report of Clayton Lockett	DPS 1-12 (OAG/JDH/Warner 0088-0099)
IFS-14-07742 OK docs_ RedactedCOMP (includes lab analyses)	DPS 16-33 (OAG/JDH/Warner 0121-0138)
Tox Rpt 14-00742 (toxicology report)	DPS 63-65 (OAG/JDH/Warner 0189-0191)
Tox wksht 14-07742 (toxicology worksheet)	DPS 66-68 (OAG/JDH/Warner 0103-0105)
ifs-14-07742 SWIFS ME docsCOMP (includes toxicology report)	DPS 84-95 (OAG/JDH/Warner 0139-0150)
14-0189SI Summary (DPS Executive Summary)	DPS 105-136 (OAG/JDH/Warner 0056-0087)
2014.06.12 UFS Cohen Lockett Preliminary Autopsy Findings (Dr. Joseph Cohen's report)	FPD 1-2
Attachment D (to 2014.09.30.14 Revised Protocol) - Preparation and Administration of Chemicals	DOC 163-173 (OAG/JDH/Warner 0035-0045)

Opinion

1. In a clinical setting, the purpose of anesthesia is to render a patient insensate to the effects of a proposed intervention. When a general anesthetic is utilized, induction and maintenance of unconsciousness and lack of responsiveness to noxious stimuli is the goal and expected outcome.

2. Midazolam is known under the trade name Versed. It is the shortest acting benzodiazepine on the market. Benzodiazepines are a class of drugs primarily used for treating anxiety. They include drugs such as Valium, Ativan, and Xanax. In clinical use, midazolam is typically administered prior to the induction of anesthesia in surgical settings to treat and sedate a patient.

3. Midazolam is not intended for use as a total anesthetic. Although midazolam can be used to *induce anesthesia,* it has no analgesic properties, and without the addition of pain-relieving drugs, does not render one insensate to noxious stimuli and is not suitable as a form of anesthesia as a single drug.

4. Midazolam is not FDA-approved as the *sole drug* to produce and maintain anesthesia in minor surgical procedures. It is never used as the sole anesthetic in a procedure that involves any noxious stimuli as it has no appreciable analgesic effect. J.G. Reves, Robert J. Fragen, H. Ronald Vinik, David J. Greenblatt, Midazolam, Pharmacology and Uses, 62 Anesthesiology, 310-324 (1985).

5. Midazolam has a ceiling effect on anesthetic depth. This means that further administration of drug after a certain effect is reached has no further

effect. *See* Exhibits 2 and 3, attached to this Report.

6. Midazolam differs significantly and materially from barbiturates like pentobarbital, which are approved as sole anesthetics. Pentobarbital is a barbiturate, and unlike midazolam, it does not have a ceiling effect. Pentobarbital produces two different effects on the brain. It acts on the GABA receptor to promote GABA binding that will induce unconsciousness in the absence of noxious stimuli, and it also produces sedation directly in large doses, acting as a GABA substitute.

7. Midazolam binds to a receptor adjacent to the GABA receptor and increases effective binding of GABA to its receptor to induce unconsciousness, but unlike the barbiturates, it does not have any direct effect (the second mechanism of barbiturates) to produce deep anesthetic states. Also, once that receptor is saturated with midazolam, administration of more of the drug does not do anything further to increase the level of unconsciousness. There is a maximum effect short of EEG (brain electrical activity) silence (Physiology and Pharmacology in Anesthetic Practice, Stoelting and Hillier, 4th edition), which is why midazolam is not used to induce coma whereas barbiturates are.

8. Midazolam can also cause paradoxical reactions in vulnerable populations, such as the elderly, people with a history of aggression, impulsivity, alcohol abuse or other psychiatric disorders. A paradoxical reaction is when the drug does not work as intended. These paradoxical reactions manifest in many ways such as hyperactivity and restlessness, but are not attended by the expected sedative

effects, and are addressed by reversal of midazolam, not further administration. Midazolam can be reversed by administering the drug romazicon (trade name Flumazenil). *See* Exhibit 4.

9. Studies show that when benzodiazepines like midazolam are given in high doses to the elderly (over 65), to people with a history of aggression or impulsivity, a history of alcohol abuse, and other psychiatric disorders, there is a significant risk of a paradoxical reaction. In the prison setting—which population includes those who constitute the vulnerable populations addressed here—midazolam might not cause a prisoner to be sedated long enough for the execution to be over, and instead might induce anxiety, discoordinated movement, hyperactivity and/or aggression in lieu of sedation.

10. Midazolam has a relatively rapid absorption rate whether injected through the vein or intramuscularly. Under the circumstances surrounding Mr. Lockett's death, representations made by the State of Oklahoma included the facts that 100 mg of midazolam were administered to Mr. Lockett and that Mr. Lockett was determined to be conscious by a physician five minutes after the administration of midazolam but was determined to be unconscious seven minutes after the administration of midazolam. This is consistent with known fact that intramuscular tissue absorption occurs just minutes after the expected effect with IV administration. The reports further show that midazolam entered Mr. Lockett's circulatory system.

11. Oklahoma has a three-drug lethal-injection protocol where midazolam is the first drug administered. The second drug in Oklahoma's lethal-injection protocol is vecuronium bromide, a neuromuscular blocking agent. The third drug in Oklahoma's lethal-injection protocol is potassium chloride. This drug formula was administered to Clayton Lockett.

12. The vecuronium bromide will paralyze a prisoner and render him unable to convey pain or suffering. If conscious, a prisoner would experience a sensation akin to being buried alive, but would not be able to convey the feeling of pain or suffocation. The paralysis would camouflage any voluntary movement that might result from an incomplete loss of consciousness.

13. Vecuronium bromide also prevents the lay observer from discerning whether the anesthetic drug has been properly delivered. The only purpose of the administration of the vecuronium bromide is to make the execution more aesthetically pleasing to observers in that it reduces the ability of the individual being executed to move or show any pain associated with the execution process.

14. Potassium chloride is a caustic chemical and would cause excruciating pain to a prisoner upon injection if he is not placed into and maintained in a surgical plane of anesthesia for the duration of the execution. Oklahoma's protocol relies on midazolam to induce and maintain that surgical plane of anesthesia, but midazolam is not appropriate as a sole anesthetic agent and is incapable of reliably maintaining a surgical plane of anesthesia.

15. It is my opinion that midazolam is an unsuitable and inappropriate choice as the first drug in Oklahoma's three-drug lethal-injection protocol for three reasons. First, midazolam has a ceiling effect and therefore cannot guarantee that a person will be unconscious and insensate to the effects of the second and third drugs. Second, it has no analgesic properties; therefore even if it were able to produce unconsciousness if 500 milligrams were properly administered, the noxious stimuli of the second and third drugs can overcome its sedative effect. Third, midazolam has an increased risk of paradoxical reactions.

16. In addition to the risk that midazolam will not induce and maintain an adequate level of anesthesia, there is an additional risk that the execution team is ill equipped to assess whether the prisoner is insensate. When a condemned prisoner is subjected to a painful stimulus, such as air hunger following an injection of vecuronium bromide or the searing pain of potassium chloride, there is a significant risk that the prisoner will awaken. While a heavily sedated prisoner might not respond to name calling or a subtle pinch, that is a very different level of stimulus from being starved for air once paralyzed, or having a caustic chemical injected intravenously. As an analogy, a patient asleep might not awaken to the stroke of the eyelashes or a pinch to the finger, but would certainly awaken to a blowtorch applied to the skin. Without an adequate determination of the prisoner's depth of, anesthesia, administration of the vecuronium bromide and potassium chloride creates a significant risk of extraordinary pain and suffering.

17. Determining whether someone is truly insensate and unaware takes repetitive training and experience. The signs that someone is not insensate can be very subtle. In a clinical setting, you would typically see subtle fine motor movements such as a moving of the feet or hands. This is not something that a lay person will necessarily observe or notice, and one could not detect such movement if the limbs were covered. To ensure that an individual is insensate to noxious stimuli, that individual must be in a surgical plane of anesthesia. In clinical practice, a common way to test for a surgical plane of anesthesia is to apply a surgical clamp on the area where the incision will be made. The pain/pressure created by this clamp cannot be equated with a human being conducting a trapezius pinch, touching an eyelid, or shaking a person's shoulder.

18. Furthermore, for such protocols to be safely conducted, the subject must be continually monitored by a trained medical professional who is experienced in providing a surgical plane of anesthesia.

19. While there is no scientific literature addressing the use of midazolam as a manner to administer lethal injections in humans or in animal euthanasia, the recent execution of Joseph Wood in Arizona provides objective, scientific evidence of the inability of midazolam to produce a coma and to guarantee sufficient anesthetic depth to allow a condemned prisoner to withstand the noxious stimuli of the second and third drugs. According to the Arizona Department of Corrections, Joseph Wood was given a total of 750 milligrams of midazolam, which is 250 milligrams more than

that called for in Oklahoma's protocol. *(See* Arizona Department of Corrections Press Release, Aug. 1, 2014, at https://corrections.az.gov/article/independent-review-process-wood-execution-under way.) The ceiling effect of midazolam was demonstrated in this human administration of large doses of midazolam because these large doses did not cause cessation of breathing or prevent movement, both of which are present during extremely deep levels of anesthesia. It is also consistent with the very large doses required to cause death in animals.

20. The use of midazolam in executions amounts to failed human experimentation. Despite the lack of a previous history of use of these doses in humans, Departments of Corrections have hypothesized three highly unlikely ideas to support their lethal-injection protocols: (1) a surgical plane of anesthesia could be achieved and maintained with midazolam alone even though extrapolation of the ceiling effect data suggests otherwise; (2) that midazolam could produce a surgical plane of anesthesia at higher doses even though the drug has never been used to do so previously, is not approved by the FDA for such use and is not used clinically as a sole anesthetic; and (3) that more drug will produce a deeper level of sedation even though an understanding of midazolam's site of action dictates otherwise. In testing these hypotheses, the state of Arizona suffered a clinical experimental failure during the execution of Joseph Wood, despite using 750mg of midazolam. This experimental execution now offers proof that Oklahoma's 500 milligram dosage will not rapidly or reliably produce a deep level of anesthesia or coma, and further supports the existing published

data that there is a ceiling effect with midazolam and that higher dose of the drug do not equate to a deeper level of unconsciousness.

21. Based on the information that I have been provided thus far, it is my opinion to a reasonable degree of medical certainty that using midazolam, followed by vecuronium bromide and potassium chloride, creates a significant risk of serious harm to condemned prisoners. It also amounts to experimentation on human subjects and vulnerable populations.

22. These are my opinions based on the documents and information that I have been provided at this time. If additional information becomes available, I reserve the right to alter my opinion upon review of such information.

Signed this 26th day of November, 2014.

/s/ David A. Lubarsky
David A. Lubarsky, M.D., MBA

EXHIBIT 3

MATERIAL SAFETY DATA SHEET

Product Name: Midazolam Hydrochloride Injection, Solution with Preservative

1. Chemical Product And Company Information

Manufacturer Name And Address	**Hospira Inc. 275 North Field Drive Lake Forest, Illinois USA 60045**
Emergency Telephone	**CHEMTREC: North America: 800-424-9300; International 1-703-527-3887; Australia (02) 8014 4880**
Hospira, Inc., Non-Emergency	**224-212-2000**
Product Name	**Midazolam Hydrochloride Injection, Solution with Preservative**
Synonyms	**8-Chloro-6-(2-fluoropheny1)-1-methy1-4H-imidazo (1,5-a)(1,4)benzodiazepine hydrochloride**

2. Composition/Information On Ingredients

Active Ingredient Name	**Benzyl Alcohol Midazolam Hydrochloride**
Chemical Formula	$C_{18}H_{13}C1FN_3$-HC1
Preparation	**Non-hazardous ingredients include Water for Injection. Hazardous ingredients present at less than 1% include**

sodium chloride and disodium edetate; hydrochloric acid and/or sodium hydroxide are added to adjust the pH.

Component	Approximate Percent by Weight	CAS Number	RTECS Number
Benzyl Alcohol	1	100-51-6	DN3150000
Midazolam Hydrochloride	≤ 0.5	59467-96-8	NI2922250

3. Hazard Information

Carcinogen List

Substance	IARC	NTP	OSHA
Benzyl Alcohol	Not Listed	Not Listed	Not Listed
Midazolam Hydrochloride	Not Listed	Not Listed	Not Listed

Emergency Overview Midazolam Hydrochloride Injection, Solution with preservative contains midazolam hydrochloride, a short-acting benzodiazepine central nervous system depressant used to relieve anxiety and provide sedation. In the U.S., midazolam is subject to Schedule IV control under the Controlled Substances Act. In the workplace, midazolam hydrochloride should be considered a potent drug, potentially irritating to the eyes and respiratory tract, and a potential occupational reproductive hazard. Possible target organs include the central nervous system, gastrointestinal system, genitourinary system, cardiovascular system, eyes, skin, and possibly the fetus.

Occupational Exposure Potential

Information on the absorption of this product via inhalation or skin contact is not available. Published reports have indicated that some benzodiazepines have the potential to be absorbed

Acute Toxicity

Not determined for the product formulation. Information for the ingredients is as follows:

Ingredient(s)	Percent	Test Type	Route of Administration	Value	Units	Species
Midazolam Hydrochloride	100	LD50	Oral	1496	mg/kg	Rat
Midazolam	100	LD50	Intravenous	73, 357	mg/kg	Rat
Midazolam	100	LD50	Intravenous	50	mg/kg	Mouse
Midazolam	100	LD50	Intravascular	> 50	mg/kg	Rat, Mouse
Midazolam	100	LD50	Oral	215	mg/kg	Rat
Benzyl Alcohol	100	LD50	Oral	1040 - 2500	mg/kg	Rat, Mouse, Rabbit, Guinea Pig
Benzyl Alcohol	100	LD50	Dermal	2000	mg/kg	Rabbit
Benzyl Alcohol	100	LC50	Inhalation	> 500	mg/m3	Rat, Mouse

Aspiration Hazard

None anticipated from normal handling of this product.

Dermal Irritation/ Corrosion

None anticipated from normal handling of this product. However, repeated or prolonged exposure to benzyl alcohol, a minor component of this product, may produce mild skin irritation with redness and dryness.

Ocular Irritation/ Corrosion

None anticipated from normal handling of this product. Midazolam produced minimal eye irritation in a study in animals. However, exposure to benzyl alcohol has produced severe eye irritation in studies in

	animals. Inadvertent contact of this product with eyes may produce redness and discomfort.
Dermal or Respiratory Sensitization	None anticipated from normal handling of this product. In clinical use, allergic reactions including anaphylactoid reactions, hives, rash, pruritus have been reported infrequently.
Reproductive Effects	A reproduction study in male and female rats did not show any impairment of fertility at dosages up to 10 times the human intravenous dose of 0.35 mg/kg. Teratology studies conducted with midazolam maleate injectable in rabbits and rats at doses that were 5 and 10 times the human dose of 0.35 mg/kg did not show evidence of teratogenicity. Studies in rats showed no adverse effects on reproductive parameters during gestation and lactation. Dosages tested were approximately 10 times the human dose of 0.35 mg/kg.
Mutagenicity	Midazolam was not mutagenic in Salmonella typhimurium (5 bacterial strains), Chinese hamster lung cells (V79), human lymphocytes or in the micronucleus test in mice.

Carcinogenicity	Midazolam maleate was administered with diet in mice and rats for 2 years at dosages of 1, 9 and 80 mg/kg/day. In female mice in the highest dose group there was a marked increase in the incidence of hepatic tumors. In high-dose male rats there was a small but statistically significant increase in benign thyroid follicular cell tumors. Dosages of 9 mg/kg/day of midazolam maleate (25 times a human dose of 0.35 mg/kg) do not increase the incidence of tumors. The pathogenesis of induction of these tumors is not known. These tumors were found after chronic administration, whereas human use will ordinarily be of single or several doses.
Target Organ Effects	Based on clinical use, possible target organs include the central nervous system, gastrointestinal system, genitourinary system, cardiovascular system, and possibly the fetus.

EXHIBIT 4

CE2 HOURS Continuing Education

Paradoxical Reactions to Benzodiazepines
When to expect the unexpected.

By Mary A. Gutierrez,* PharmD,
Janice M. Roper, PhD, RN,
And Pockhee Hahn, RN

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Benodiazepines are among the most frequently prescribed medications in the United States; alprazolam, diazepam, diazepam, lorazepam, and temazepam are among the 200 most often prescribed.[1] Benzodiazepines are used in the treatment of anxiety, insomnia, and neuromuscular and seizure disorders; as preoperative medications; and to manage alcohol withdrawal. The goal is to induce a feeling of calm and relaxation, and typical side effects include sedation, psychomotor impairment, and anterograde amnesia. But in some people—as few as 1% or as many as 29%,[2] primarily children, the elderly, and those with poor impulse control—the opposite effects occur (see *Patients at Risk,* page 35). These patients have "paradoxical" reactions, characterized by emotional

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liability, agitation, and occasionally rage, instead of the expected calming effect. In about 7% of cases, the reaction is severe and necessitates the discontinuation of the benzodiazepine and, less frequently, treatment with a benzodiazepine antagonist.[2]

Benzodiazepine withdrawal is known to cause rebound symptoms, such as anxiety and insomnia, but few providers are aware that agitation and rage can result from appropriate administration of the drug itself. Consequently, paradoxical reactions to benzodiazepines are often incorrectly assessed as non-drug-related agitation, which is treated by increasing the benzodiazepine dose, leading to further disinhibition. This article presents a review of the available literature on paradoxical reactions to benzodiazepines and discusses nursing management options.

PHARMACOKINETICS

All benzodiazepines share comparable pharmacologic properties, acting as anxiolytics, sedative-hypnotics, myorelaxants, amnesics, and anticonvulsants.[10] They differ primarily in potency (the dosage needed to attain the desired effect) and pharmacokinetic profile. Benzodiazepines are generally divided, depending on their elimination rates, into three categories: short-, intermediate-, and long-acting agents. *The Pharmacokinetics of Benzodiazepines,* page 36, summarizes the pharmacokinetic profiles of the benzodiazepines available in the United States.

The benzodiazepines most frequently associated with paradoxical reactions are the triazolobenzodiazepines, a class of benzodiazepines that are highly lipid soluble and highly potent and that bind with high affinity to the receptor. Two high-potency triazolobenzodiaze-

pines, alprazolam and triazolam, have been most commonly reported to produce adverse central nervous system (CNS) reactions, including paradoxical effects. Midazolam, used mostly intravenously for preoperative or preprocedural sedation, is associated with a similarly high incidence of paradoxical reactions.

CASE REPORTS

The disinhibitory effects of benzodiazepines have never been studied systematically; they've been described in the literature primarily in short case reports. Many of these case studies provide insufficient information and are limited in their ability to control for factors such as other drugs or underlying psychological problems that contribute to disinhibitory effects, making interpretation difficult. These reports of paradoxical reactions to benzodiazepines warrant further investigation.

Temazepam and triazolam. During an 18-month period, 10 cases of agitation and episodic uncharacteristic anger were reported in patients receiving temazepam and triazolam in a sleep clinic.[12] There were no such effects associated with the use of other benzodiazepines. The researchers initially speculated that the observed effects were secondary to daily withdrawal, because these benzodiazepines hadn't been administered regularly and they have shorter half-lives. Upon discontinuation of either of the two benzodiazepines, the patients' symptoms remitted within days. Comparable symptoms, such as constant anger and easily provoked rage, reemerged in two patients when temazepam was restarted (the other patients were not rechallenged with this benzodiazepine). Note that in these cases the triazolam doses were 0.5 mg or higher, in excess of the recommended maximal dose of 0.25 mg per day.

Alprazolam. A double-blind, placebo-controlled crossover study showed a significant worsening of serious inappropriate impulsiveness in patients with borderline personality disorder taking alprazolam compared with those receiving placebo.[5] Seven (58%) of the 12 patients taking an average daily dose of alprazolam 4.7 mg had episodes of serious disinhibition, such as increased incidence of hurting themselves or others, during the six-week medication trial, compared with one (8%) of the 13 patients taking placebo. Because patients with borderline personality disorder often have poor impulse control that could be exacerbated by disinhibition, alprazolam apparently caused more severe, frequent, and unpredictable inappropriate impulsiveness in these cases.

The authors concluded that caution should be exercised when using alprazolam to treat patients who are predisposed to the disinhibitory effects of benzodiazepines, such as those with poor impulse control.

Midazolam. Rodrigo reported a midazolam-induced reaction of severe aggressive behavior in a female patient undergoing dental surgery; the aggression escalated with further increments of midazolam.[6] Flumazenil, a benzodiazepine antagonist that selectively abolishes all centrally mediated effects of benzodiazepines at the receptor level, was used to treat the paradoxical reaction, and the patient underwent the procedure without further complication. Honan reported a similar paradoxical reaction to midazolam, which was also controlled with flumazenil, in a male patient undergoing endoscopy.[7] Other researchers continue to report midazolam-induced paradoxical reactions, which have been reversed by flumazenil.[8, 9]

Thurston and associates described a 27-year-old man who became agitated, anxious, and restless after receiving midazolam 2 mg IV.[13] An additional midazolam 5 mg was administered over the following 10 minutes, with no abatement of symptoms. On the postanesthesia care unit, lorazepam was administered when the patient continued to be agitated and restless. When his status still had not improved, flumazenil 0.1 mg was administered, followed by another 0.2 mg two minutes afterward. Within two minutes of the second dose, the adverse symptoms resolved completely.

The Pharmacokinetics of Benzodiazepines

Short acting			
Midazolam† (Versed)	IV: 0.1 to 0.33 PO: 1 to 4	Yes	CNS depressant used for preoperative sedation or anxiolysis (injection and syrup).
Oxazepam (Serax)	3 to 5	No	An anxiolytic not for use IV. Onset of action is 3 to 6 hours because of high hydrophilicity. Needs to be scheduled TID or QID because of short half-life.
Triazolam† (Halcion)	1.6 to 5.4	No	A hypnotic with short duration and fast onset. Good for difficulty falling asleep.
Intermediate acting			
Alprazolam† (Xanax)	12 to 15	No	An anxiolytic approved for panic disorder, up to 10 mg/d (up to 4 mg/d for generalized anxiety disorder).
Estazolam (ProSom)	10 to 24	No	A hypnotic with a profile comparable to temazepam's.
Lorazepam (Ativan)	10 to 20	Yes	An anxiolytic, the best as benzodiazepine because its rate of absorption is most predictable.
Temazepam (Restoril)	10 to 20	No	A hypnotic with slow dissolution rate (onset of action, 1 to 3 hours); good for difficulty staying asleep.
Long acting			
Chlordiazepoxide (Librium)	Parent drug 5 to 30; active metabolite (desmethyldiazepam) 30 to 200	Yes	An anxiolytic commonly used for alcohol withdrawal, not to exceed 300 mg/d.
Clonazepam (Klonopin)	18 to 50	No	A long-acting anxiolytic and anticonvulsant without active metabolite.
Clorazepate (Tranxene)	30 to 200	No	An anxiolytic needing the acidic GI tract to convert to its active metabolite, desmethyldiazepam.
Diazepam† (Valium)	Parent drug 20 to 50; active metabolite (desmethyldiazepam) 30 to 200	Yes	An anxiolytic with potential for abuse because of high lipid solubility (that is, rapid onset).
Flurazepam (Dalmane)	47 to 100	No	A long-acting hypnotic; accumulation of metabolite may lead to daytime psychomotor impairment.
Quazepam (Doral)	Parent drug 25 to 41; active metabolite (N-desalkyl-2-oxoquazepam) 70 to 75	No	A hypnotic with a profile comparable to flurazepam's.

†Risk of paradoxical reactions may be higher when drugs are given parenterally.
‡Benzodiazepines carrying higher risks of paradoxical reactions.
Source: American Society of Health-System Pharmacists. AHFS drug information. McEvoy GK, editor. Bethesda (MD): The Society; 2001.

Diazepam. Seven children affected by infantile autism who were given diazepam 10 mg IM demonstrated paradoxical behavior (anxiogenic effects; socially inappropriate, aggressive behavior; and explosive aggression).[4] Although the children displayed some baseline aggression, the authors noted

that it increased significantly after benzodiazepine treatment.

THE NEUROPHYSIOLOGIC BASIS

Benzodiazepines normally exert their effects by enhancing those of gamma-aminobutyric acid, the primary inhibitory neurotransmitter in the limbic, thalamic, and hypothalamic areas of the CNS. Although there are many hypotheses about the etiology of benzodiazepine-induced disinhibitory effects, they've been neither fully elucidated nor proven. Several researchers, however, have put forth theories about common risk factors.

Serotonin imbalance. Paradoxical rage reactions apparently occur once the drug has caused a partial deterioration of the patient's socially acceptable behavior. This drug-related disinhibition, according to Senninger and Laxenaire, leads to an exaggerated display of the patient's underlying character pathology and aggressiveness.[14] The researchers propose that the disinhibition phenomenon is based on a serotonergic mechanism; imbalances of serotonin can lead to aggression and various psychiatric disorders.

Central cholinergic mechanism. A review by Van der Bijl and Roelofse of disinhibitory effects of benzodiazepines examined the many theories about the means by which paradoxical reactions occur. They concluded that the exact mechanism is unclear but it appears likely that a central cholinergic mechanism contributes.[3] They based this conclusion on several cases of paradoxical reactions to benzodiazepines that were reversed with the use of physostigmine, a reversible inhibitor of cholinesterase.[15, 16] (Physostigmine was used as an antidote before flumazenil received FDA approval in 1991.) The investigators

proposed that physostigmine either acts as an indirect antagonist to the benzodiazepine receptor or affects cerebral metabolism via central cholinergic mechanisms. Significant decreases in central cholinergic activity can lead to delirium and disorientation.

Genetics. Short and colleagues, who suggested that paradoxical reactions to benzodiazepines may be genetically predetermined, reported a case of monozygotic twins with marked midazolam-induced restlessness.[17] But no other reviews or studies support or verify this finding.

Idiosyncrasy. Hall and Zisook concluded that in studies of aggressive behavior in humans the effects of benzodiazepines upon such behavior are difficult to define for several reasons: the nature of the study populations, the individual nature of dose–response relationships, unclear assessment criteria, the lack of double-blind studies designed specifically to assess benzodiazepine-induced paradoxical reactions, and the underlying psychological basis for the initiation of drug therapy.[18] They deduced that because the overall incidence of significant paradoxical responses to benzodiazepines is extremely small, these reactions seem to be idiosyncratic.

A review of 45 double-blind clinical efficacy trials involving more than 5,400 patients noted no disinhibitory effects in patients treated with triazolam 0.25 mg or 0.5 mg per day or in patients treated with flurazepam 30 mg per day.[19]

Handling Unanticipated Changes in Mental Status

How to respond when you encounter paradoxical reactions

Your first clinical experience with a paradoxical reaction to benzodiazepines may be as unexpected to you as it is to your patient. The first thing you may note is unpredicted changes in mental status and behavior. Although a paradoxical reaction may be the cause, you probably won't be sure until you've ruled out possible causes such as an infection or compromised airway. After obtaining vital signs and oxygen saturation readings, perform a brief neurologic evaluation by assessing global orientation and the patient's ability to follow commands; look for any signs of neurologic insult (such as facial drooping or extremity weakness).

Safety is a high priority, particularly in a patient who becomes confused or agitated. Keep him in bed with the side rails up. Reorient as needed, and have a health care provider or family member stay with him to provide ongoing supervision. Avoid restraints; they're likely to heighten anxiety and agitation. Ask the patient's family if he has had other reactions to benzodiazepines. Also, keep in mind that the paradoxical reaction will last according to the half-lives of the particular medication and its active metabolites. For example, alprazolam has an intermediate half-life (12 to 15 hours) with no active metabolites, whereas diazepam has both a long half-life (20 to 50 hours) and three active metabolites (one of which is mentioned in *The Pharmacokinetics of Benzodiazepines*, page 36).

The possibility of a paradoxical reaction may occur to you only after you've ensured the patient's safety and ruled out all other causes. It may be only after review of the patient's medications that you connect benzodiazepine use with changes in mental status and behavior.

After the episode, be sure to discuss it with the patient and his family. A paradoxical reaction doesn't necessarily rule out future benzodiazepine use. Rather, it may necessitate a lower dose and the nurse's awareness of the medication's half-life and, if present, metabolites. Nurses should also consider the possibility of drug interactions and assess for predisposing metabolic or organic factors.—*James M. Badger, MSN, RN, CS, clinical nurse specialist, Departments of Nursing and Psychiatry, Rhode Island Hospital, Pr*

Poor impulse control. The risk of paradoxical reactions may depend on the sample population studied; a greater number of reactions may be observed in patients with underlying impulse-control disorders than in the general population. Some investigators have suggested that rage reactions to

benzodiazepine administration are predictable in those with a history of poor impulse control or aggressive and destructive behavior. In such patients, DiMascio and colleagues noted, chlordiazepoxide and diazepam may have uncovered latent hostility by altering the threshold of inhibitory control, causing a rage reaction.[20] Oxazepam is the benzodiazepine of choice in these patients, the authors said, because no rage reactions have been reported in those taking it.

Because oxazepam is not commonly used, researchers are unsure of the drug's relationship to rage reactions (that is, such reactions may be underreported). In one study, however, Kochansky and colleagues compared patients who received chlordiazepoxide 30 mg per day with those taking oxazepam 45 mg per day or placebo. The researchers observed increased hostility in the patients taking chlordiazepoxide but not in those taking either oxazepam or the placebo.[21]

Edwards and Medlicott reviewed several studies suggesting that benzodiazepine use can cause an inability to refrain from acting upon underlying aggressive impulses and that significant disinhibition may result in assaultive behavior.[22] They also suggested that an increased potential for benzodiazepines to cause patients who are depressed to attempt suicide is a result of this disinhibitory effect.

MANAGEMENT

Although paradoxical reactions are neither common nor predictable, it's important for both clinicians and patients to be aware of their potential to occur.[19, 23] A thorough medication history and careful inquiry regarding comparable adverse reactions should be

completed (see *Handling Unanticipated Changes in Mental Status,* page 37).

If a patient with a history of either poor impulse control or benzodiazepine-induced disinhibitory effects needs benzodiazepine therapy, the prescribing clinician may consider a benzodiazepine associated with fewer adverse CNS effects. Oxazepam, for example, is the most hydrophilic benzodiazepine and may induce fewer adverse CNS effects. Note, however, oxazepam's slow onset of action because of its hydrophilicity (three to six hours). For this reason, and because of its short half-life, oxazepam should be used on a scheduled, divided daily dose.

Among benzodiazepines, the triazolobenzodiazepines—such as alprazolam and triazolam—have generated the greatest number of reports of adverse CNS effects (for example, mania, anterograde amnesia, and disinhibition). Therefore, the triazolobenzodiazepines should be avoided in patients with a history of either poor impulse control or benzodiazepine-induced disinhibition. The structural and molecular similarity of the triazolo ring in these benzodiazepines may enable them to interact with receptors not usually affected by other benzodiazepines.[24] Three case reports describe acute paroxysmal excitement associated with alprazolam treatment.[24] Although estazolam is also a triazolobenzodiazepine, there haven't been any reports of it causing paradoxical reactions. This may be because of the infrequent use of this hypnotic, as well as its lower lipid solubility. The frequent reports of midazolam-induced disinhibition may be a result of its high potency, higher lipid solubility. The frequent reports of midazolam-induced dishibition may be a result of its high potency, higer lipid solubility, and the route of administration (it's usually administered

parenterally)—benzodiazepine properties that are thought to cause paradoxical reactions.

When a patient given a benzodiazepine exhibits agitation, hostility, aggression, or excitability, the clinician should consider discontinuing the benzodiazepine rather than adding to it to alleviate the problem. If the patient's symptoms abate upon discontinuation, the clinician should document clearly that benzodiazepine-induced disinhibition is a possibility, warranting either further observation or avoidance of benzodiazepines altogether. When the paradoxical reaction is severe, flumazenil may be considered.'

Small doses of flumazenil 0.2 mg IV can be used to counteract benzodiazepine intoxication or excessive postoperative sedation.[10] The drug may also have a role in reversing paradoxical reactions to benzodiazepines.[7, 13] Flumazenil has a fast onset (seconds to minutes) but a short duration of action (two to three hours), necessitating careful clinical observation and, sometimes, repeated administration.[26] Flumazenil must be used cautiously in patients who have used benzodiazepines chronically, because of the potential for abrupt-withdrawal seizures.

Some general guidelines may help reduce risk:

- Patients should be advised not to exceed the prescribed daily dosage and not to double the dose if they miss one.
- Patients should avoid alcohol and all over-the-counter anxiolytics, such as kava and valerian, while taking benzodiazepines, because additive CNS depression may result.

- Patients should inform their prescribers and pharmacists of their complete daily medication regimens (including prescription, over-the-counter, and herbal medications) to preclude potential drug interactions that can increase benzodiazepine concentrations.
- Patients taking alprazolam, estazolam, midazolam, and triazolam should avoid drinking grapefruit juice, a cytochrome P-450 3A4 isoenzyme inhibitor that can increase the concentrations of these benzodiazepines.

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-665-F

CHARLES F. WARNER, ET AL.,

Plaintiffs,

vs.

KEVIN J. GROSS, ET AL.,

Defendants.

TRANSCRIPT OF PRELIMINARY INJUNCTION
HEARING BEFORE THE HONORABLE
STEPHEN P. FRIOT
UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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* * * *

[102] proceed.

DAVID LUBARSKY,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MS. KONRAD:

Q. Good afternoon, Dr. Lubarsky. Can you hear me?

A. I can.

Q. If at any time you can't hear me or if there's a problem with the sound, just let me know. Okay?

A. Okay.

Q. Please state your name—your full name for the record.

A. David Allen Lubarsky.

Q. And what is your specialty, Dr. Lubarsky?

A. I'm an anesthesiologist.

Q. And how long have you been anesthesiologist?

A. I began my training some 30 years ago, and I have been a board certified anesthesiologist for the last 25 years.

Q. And what is your current position?

A. I am the Emanuel M. Papper Chair and Chairman of the Department of Anesthesiology at the University of Miami. I'm also the chief medical officer of their health system.

Q. And do you treat patients in your position?

A. I do.

Q. And have you been deemed an expert in the past?

A. I have.

[103] Q. Let me rephrase that, an expert in federal court?

A. I have.

Q. And have you testified regarding lethal injection protocols in other jurisdictions?

A. I have testified about lethal injection in other jurisdictions, yes.

Q. And what jurisdictions have you testified about their lethal injection protocols?

A. Over the course of the last few years, I have been in Florida and Alabama to give testimony.

Q. Okay. And I want to just ask you quickly about Florida. What type of protocol were you providing testimony about in Florida?

A. I was providing testimony about the use of midazolam as the initial drug in a three-drug protocol.

Q. I'd like to turn your attention to Exhibit 80, Plaintiffs' Exhibit 80, which is marked as your report. Do you have that in front of you?

A. I do. Just turning to it now. Yes, I have it in front of me.

Q. And that is the report that you authored in this case, correct?

A. It is.

Q. And you also have four exhibits attached to your report; is that correct?

[104] A. I do.

Q. And you've also reviewed some documents in this case before writing your report; is that correct?

A. I did.

Q. And just for the record, I'm going to go through quickly the exhibit numbers of the documents that you reviewed before authoring your report, Exhibit 65, which is the DPS executive summary, you've reviewed that?

A. I have.

Q. Exhibit 66, which is the Dallas County autopsy report, you've reviewed that?

A. I have.

Q. Exhibit 68, you were provided with the chemical protocol, which is Attachment D to Exhibit 68, called the Preparation Administration of Chemicals, have you reviewed that?

A. Yes, I have.

Q. And you were provided with Exhibit 70, which was the preliminary autopsy findings of Dr. Cohen; is that correct?

A. Yes, that is correct.

Q. And you've reviewed some of the documents provided with the DPS executive summary, which is labeled as Exhibit 71; is that correct?

A. That is correct.

Q. And since your report was submitted, you've reviewed a few other expert reports; is that correct?

[105] A. Yes.

Q. You've reviewed Defendants' Exhibit 34, which is a letter from Dr. Evans to John Hadden dated December 2nd?

A. Yes. I have to see if I have that with me here. Yes, that is correct.

Q. Okay. I want to ask you now—turn to your opinion and take a look at your report. So we'll just kind of walk through your report if you want to have that in front of you for reference so we're both on the same page.

A. Okay.

Q. And are you having any trouble hearing me? Because there's a delay in the video stream, I just want to make sure there's no delay in the sound.

A. No. The sound seems to be working just fine.

Q. Okay. So let's talk a little bit about the drug midazolam. And I want to talk about what your experience with this drug is, so I'm going to ask you to provide a little bit of background about the drug and just consistent with your report, what is this drug and what is your experience with this drug—or, actually, let me ask the first question, what is this drug?

A. So midazolam is one of a class of drugs known as benzodiazepines. They're meant primarily to reduce anxiety and produce mild sedation with a relatively high level of safety and were developed with that specifically in mind.

[106] Q. Okay. And what is your experience using this drug?

A. I've been using this drug essentially since it came out on the market many years ago, and we use it daily in all of our operating rooms for almost every patient in very small doses. And I would probably say that in my experience overseeing both the clinical operations at Duke University as the vice chair and my role as chairman at the University of Miami that I've probably overseen its administration in one way, shape, or form indirectly a million times.

Q. Okay. And what purposes are you using this drug for in your profession?

A. The drug is almost routinely used, at least for anesthesiologists, as the first drug that we give to patients in the preoperative holding area to make sure that the anxiety of entering the operating room is

not overwhelming. As I'm sure anybody who has undergone an operation, they're very, very nervous and this kind of calms the butterflies, if you will, in their stomach about giving over their lives to the hands of other people.

Q. And have you used it to induce anesthesia?

A. When the drug first came out, we—I did personally use it in that regard, but it is almost never used that way anymore. I certainly don't think I've seen it used for induction of anesthesia, except on the rare occasion to teach a trainee something, but routinely used virtually never because [107] it doesn't work very well in that regard.

Q. Okay. And I'm going to talk about your statement in paragraph 3 on page 2 of your opinion. You say midazolam is not intended for use as a total anesthetic. Explain to me what that means and provide the Court with some information about the term "anesthesia."

A. Sure. So anesthesia is basically rendering a patient insensate to noxious stimuli. When you are talking about a general anesthetic, you are talking about immobility, a lack of sensation, and a lack of consciousness as noxious stimuli are applied. Midazolam does not work to produce that outcome. This has been recognized since its introduction. And that is why it is not recommended and not approved by the FDA for being used as a sole drug during a surgical procedure because it is not sufficient to produce a surgical plane of anesthesia in human beings.

Q. Okay. Well, let's talk about the properties of midazolam and you make some opinions in your report. And let's talk first about what you mention

that it has no analgesic properties, and that's in paragraph 3. What does that mean?

A. That means that the drug does not block pain impulses coming from different parts of the body. Meaning things like surgical incision, manipulation of the bowel, injection of caustic substances. Those would not be blocked. And in some cases, these class of drugs can actually amplify the pain [108] itself. They're ant-analgesic (sic), meaning they amplify pain signals. But primarily, basically, it has no appreciable analgesic effect under any circumstances.

Q. And have you ever heard that it has been used for back pain?

A. Yes. It is used to—because one of its properties is to reduce muscle spasm. And when it does that, if muscle spasm is the cause of nerve compression or distortion of the back anatomy, midazolam will reduce the pain that has been caused by compression of the nerve or the distortion of the anatomy. It has no direct effect to mask the pain, for instance, the way that ibuprofen or Advil might do or morphine might do. It acts—its only action is in reducing muscle tone.

Q. So if somebody were suffering back pain that wasn't caused by muscle spasms, then that would not have any effect on the person?

A. Correct. It would be useless.

Q. Now, I want to bring you to paragraph 5 on page 3 of your report. And you say that midazolam has a ceiling effect on anesthetic depth. Can you explain what that means?

A. Sure. It simply means that when you give a certain amount of drug you expect a certain effect. And people normally assume that, well, if you give twice as

much of the drug you would get twice that effect. That's not the case with midazolam. It reaches a level of sedation and inhibition of [109] firing of the neurons in the brain and you get no more. Despite if you brought a truckload in, you would get no more effect because of the way that it works. It saturates the site where it has an effect and that effect is short of providing a comatose state. And so giving more drug doesn't do anything more. That's the definition of a ceiling effect.

Q. And is this different from a barbiturate?

A. Yes, it is. And the reason is because the two drugs are entirely different classes of drug. They're substantially different. One has been approved as a sole anesthetic, that is barbiturates, you can actually do a full operation with a barbiturate. You cannot do that with midazolam. The reason for that is that midazolam basically makes the nerve cells bind GABA more easily. GABA is a normally occurring substance that makes it hard for the neuron to fire. And if the neuron isn't firing, you're not thinking, you're not feeling. Okay? So it makes it easier for that inhibition to occur. Barbiturates have initially the same type of action, but as the doses increase, they go from just changing the way the receptor works to actually acting as a direct drug agonist. Essentially, the barbiturates substitute for the GABA and act like GABA, which directly inhibits the neurons from firing. Midazolam does not do that.

Q. So explain to us—can you give us an example that might help us understand a little bit better than knowing all these [110] scientific terms?

A. Yes, I'm sorry. I wish that—I wish that it were simpler, but as neurophysiology and cognition are not

easy topics for anybody, even for physicians, to really grab hold of.

THE COURT: Well, excuse me. First of all, what is a GABA receptor?

THE WITNESS: Right. Sorry. So a GABA receptor is a—not using technical terms, it is a binding site for a naturally occurring substance in the brain that promotes the neurons not firing. It says—when GABA is bound, it's much harder for a neuron in the brain to send along an electrical impulse. And so that's where both midazolam and barbiturates act, but they act via different mechanisms on that same receptor and they act in different strength on that receptor. Midazolam strength is much less than the barbiturate strength in that regard.

Q. (BY MS. KONRAD) And just to be clear, is pentobarbital a barbiturate?

A. It is.

Q. Is sodium thiopental a barbiturate?

A. Yes, it is.

Q. And if those drugs are given in large doses, would you expect somebody to become in a coma—in a state of coma?

A. If you gave enough of those drugs, you would achieve that [111] end point. That's where the definition of the term "barbiturate coma" comes from. And it's used often in intensive care units following things like traumatic brain injury or other types of brain injury to quiet the brain. Of note, they don't use midazolam for that.

You had asked—if I may answer the question that was previously asked about trying to explain this in non-scientific terms, perhaps, if that's possible.

MS. KONRAD: Judge, will you allow—

Q. (BY MS. KONRAD) Yes, go ahead.

A. So if you think about the fact that the GABA receptor allows ions to flow in and out of the neuron, it's like people basically coming in and out of a courthouse. And let's say that you want to get a bunch of people into the courthouse and you have two doors that are open and eight doors that are shut. And if you send—if you send four people over to open up four more doors, a lot more people can come in more quickly. If you sent another four people and open up all ten doors and hold those doors open, because you have to hold the door open, then you're going to get maximum flow in and out of that courthouse. If you send another hundred people to hold open those ten doors, there will still only be ten doors open and there will still only be so many people flowing in and out of the courthouse. That's the way midazolam works.

Barbiturates are different. Because those people happen [112] to have sledge hammers in their back pocket. So first you send four people to open four doors, now you've got six open. You send another four people, you've got ten open. Now you send a hundred other people and they find that, well, they really can't have any impact by holding open the door, so they go to the windows next to the doors and they start sledge hammering them and opening up new portals. That's a different mechanism of providing access in and out. And that's what barbiturates do that are different than what midazolam does. It's a difference between having a ceiling effect and not having a ceiling effect

because sending more people with sledge hammers will open up more holes in the courthouse. Sending people just to hold the door open won't have an effect. So that—I don't know if that helps at all, but that is basically the difference between the two drugs.

Q. Thank you for that. We mentioned coma. What is coma?

A. So coma is the cessation of cortical activity and a depression of the reticular activating system which promotes retention memory and processing of stimuli.

Q. And you indicated earlier, I believe I heard you say that midazolam cannot be used to induce a coma. And why is that?

A. Because it's simply not strong enough to reduce all electrical signaling even at maximal effect in the brain. So a coma essentially says that you have EEG silence. That is the electrical activity in the brain has stopped and you're not [113] really processing any more inputs and you're not having any more independent thought. Midazolam cannot do that. It has been studied both in rats and in humans and it has what's called a sigmoidal Emax curve, which is scientific terms for ceiling effect. It gets to a certain point and there's still EEG activity left.

Q. And is that opinion based on your own personal experience and studies or is that based on other people's studies? How are you basing that opinion?

A. There is both published rat and human studies that have directly studied this and developed those curves and it has been shown in human trials for traumatic brain injury that it neither reduces intracranial pressure nor produces electrical silence and distinction to barbiturates, which do both.

THE COURT: Excuse me. When you refer to cessation of EEG activity, are you essentially—is that the same thing as electrical silence?

THE WITNESS: Yes, it is.

THE COURT: Go ahead.

Q. (BY MS. KONRAD) And are you familiar with the term "brain death"?

A. I am familiar with the term "brain death."

Q. And what does "brain death" mean?

A. Brain death actually has a complex definition, but the most important one is an absolute lack of thought processes, [114] plus brain stem reflex absence, which means there is no breathing and there is no effort at breathing. That's one of the primary differences between coma and brain death.

Q. Okay. I'd like to turn your attention to paragraph 8 of your opinion on page 3 where you talk about a paradoxical reaction. Could you explain for the Court what a paradoxical reaction is and what does that mean?

A. Sure. So all benzodiazepines have, as a class of drugs, been associated with a reverse effect, if you will, than that anticipated. You're supposed to have anxiolysis sedation and quieting of the patient with the administration of a benzodiazepine. Somewhere between 1 and 11 percent of patients, depending on the drug and the patient themselves, will experience agitation, combativeness, and anxiety as a result of the administration of the drug, hence the term "paradoxical."

Q. And you mentioned the term "anxiolysis." Could you explain what that means?

A. That just means reducing anxiety, getting rid of anxiety.

Q. So rather than reducing anxiety, it has a different effect that—does it cause anxiety?

A. There's an outward manifestation that looks like anxiety, yes.

Q. And have you ever administered midazolam and seen a paradoxical reaction?

[115] A. I have.

Q. And what happens when that occurs? What do you do to treat it?

A. Well, the recommended treatment and the one that has worked in my personal experience as well as that that's recommended in the literature is the reversal of midazolam, not further administration, but reversal of midazolam with a drug known as Flumazenil.

Q. And what would you expect to happen if you administered additional midazolam if somebody was having a paradoxical reaction to midazolam?

A. They would manifest a—well, in the cases where people have given additional drug thinking they just hadn't given enough, the paradoxical reaction—

THE COURT: Doctor, I'm going to ask you to slow down just a little bit, please.

THE WITNESS: Sorry about that. In the instances where the drug has been further administered after a paradoxical reaction has begun, the patient has simply worsened and gotten more antsy, more aggressive, more combative, and less stable. So sooner or later, they all get reversed.

THE COURT: Sooner or later they do what?

THE WITNESS: They get reversed—they will get a reversal drug or the drug will wear off.

Q. (BY MS. KONRAD) And is there certain populations that are

* * * *

[117] at approximately 60 minutes.

Q. I'm sorry. I didn't understand your last—how many minutes?

A. I said a peak effect—a peak effect from intramuscular injection probably in the 45- to 60-minute range.

Q. In your opinion, approximately how long would it take for someone to become unconscious if administered an IV dose of midazolam of 500 milligrams?

A. No more than a couple of minutes for sure, probably less.

Q. And you said you reviewed the DPS executive summary, which we've marked as Exhibit 65. If you could turn to that exhibit now.

A. Yes.

Q. Okay. I'm going to turn your attention to page 11.

A. Yes.

Q. And if you look at the timeline there, it notes that at 6:23 the execution of Mr. Lockett began and a full dose of midazolam and appropriate saline flush were administered. Do you see that?

A. Yes.

Q. And then at 6:30 it says that the signal was given, five minutes had elapsed, and the physician determined Lockett was conscious. And then it says at 6:33 the signal was given, two minutes had elapsed, and the physician determined Lockett was unconscious. Do you see that?

[118] A. I do.

Q. And then it indicates that the full dose of vecuronium bromide and a majority of the potassium chloride were administered. Do you see that?

A. I do.

Q. And are you aware of the amounts of the drugs that were given during Mr. Lockett's execution?

A. I am.

Q. And on page 24 it references the amounts, which is the 100 milligrams of midazolam, the 40 milligrams of vecuronium bromide, and 200 milliequivalents of potassium chloride, which they indicated only part of that was given. And then I want you to look at page—sorry, one moment—at page 18 of the DPS report. And it's the second full paragraph at the last sentence. It says, "At some point during the administration of these two drugs Lockett began to move and the physician recognized there was a problem." Do you see that?

A. Yes, I do.

Q. Based on this and based on all the other information you read, do you have an opinion, based on this information, whether Mr. Lockett became unconscious from the administration of midazolam?

A. Taking everything at face value and the descriptions, I believe that Mr. Lockett did become

unconscious as indicated in the timeline and from the descriptions that have read [119] elsewhere, yes.

Q. Now, based on accounts of witnesses who observed Mr. Lockett trying to pull up off the table and bucking, speaking, writhing, do you have an opinion whether Mr. Lockett awoke from unconsciousness at some point after he was deemed unconscious?

A. I do have an opinion and that opinion is that he most definitely awoke and that the descriptions as written here are, unless conclusively proven otherwise, indicative of someone who was awake and struggling against the effects and the pain of the other drugs.

Q. Now, on page 18 of the DPS report, it indicates that the IV line had infiltrated. What does that mean?

A. That means that the medicine at some point is no longer going into the vein and into the blood system but being deposited next to the vein and into the muscular tissue or fatty tissue around where that blood vessel is.

Q. And on paragraph 12 of your report you mentioned vecuronium bromide and we talked about that was administered to Mr. Lockett during his execution. What—do you have an opinion whether Mr. Lockett was administered drug into—this drug, the vecuronium bromide, into his tissue?

A. Well, I cannot be sure. It is most likely that the vecuronium bromide was injected into the tissue based on the descriptions given.

[120] Q. And what would it feel like if someone were administered vecuronium bromide while being aware?

A. So, first of all, the volume of drug itself would be extremely painful if injected with—at that volume

into any tissue space. So there is the specific direct pain. But the greatest difficulty that someone would experience would be the feeling of gradual suffocation, the inability to draw one's breath, air hunger, and a progressive suffocation and being quite aware of that.

Q. Could Mr. Lockett have been administered a sufficient dose of vecuronium bromide if he was moving and speaking?

A. He could not have been given the vecuronium bromide intravenously at that dose and still been moving and thinking. That would be inconsistent with the action of the drug.

Q. And let's talk about the third drug that was administered in part and that's the potassium chloride. And you speak about that in paragraph 14 of your report. What is potassium chloride?

A. Potassium chloride is basically a salt. It's just an electrolyte. Both potassium and chloride are found in the body normally, but it primarily resides inside your cells and not outside your cells. And when given, it causes intense pain.

Q. And when you say "intense pain," do you have any description of what type of pain?

A. It has been described as liquid fire when people have [121] accidentally gotten intravenous injections of potassium chloride and been awake. Excruciating, searing, burning.

Q. Do you have an opinion whether Mr. Lockett was likely suffering upon the administration of either the vecuronium bromide or the potassium chloride during his execution?

A. I do. I believe that he suffered upon the injections themselves. He continued to suffer. The

potassium chloride causes tissue necrosis relatively rapidly. It kills the tissue into which it has been injected. And the progressive suffocation due to the slow onset of paralysis would be nothing short of agonizing.

Q. And would it matter, in your opinion, if some of the witnesses had varying accounts of what they were viewing as far as his movements or his sounds, speaking? Some people heard words and some people heard mumbling. Would that change your opinion regarding consciousness?

A. No, not at all. People who are asleep don't make efforts to speak to you. They don't rise up off the gurney. They don't disticulate with their torso. I can imagine that surgery would not proceed very far if anesthetized patients ever did that.

Q. All right. Let's turn to the current lethal-injection protocol in Oklahoma, which is Exhibit 68. And could you turn to Chart D that's in Attachment D.

A. Yes. Okay. Attachment D, did you say?

* * * *

[124] A. It's in the ballpark range. It's not—that's not how people necessarily practice. I've almost never seen anybody get less than 2 to 3 milligrams. Two milligrams is usually the minimal amount that has any effect. But in the 2 to 5 milligram range is what we routinely use as a preanesthetic. But I will point out that after having given that dose, we're still having totally coherent conversations with a wide-awake patient who is just no longer anxious when we're done with our dosing.

Q. And is that the dose that would produce unconsciousness as a sole drug?

A. No, it would never produce unconsciousness at that rate if you were—unless you had a severe preexisting disease.

Q. And at the end, the last sentence of his paragraph, he says, Fatalities have occurred from midazolam in doses ranging from .04 to .07 milligrams per kilogram. Do you have an opinion about that statement?

A. Again, that is true, it is a true statement, but the part that's left out is that those type of fatalities occur in 90-year-olds with congestive heart failure who have not had careful titration of the drug. It does not occur in otherwise healthy individuals in that range. And I don't—I'm not aware of young healthy individuals who have ever been administered 2 milligrams who have had a respiratory arrest reported.

[125] Q. He also says that the 500 milligrams of midazolam that will be used in executions in Oklahoma, this first sentence of his second paragraph under midazolam he references that, and he says this dose is at least 100 times the normal therapeutic dose. Would you agree with that?

A. No, I would not. What you're attempting to do with an execution is provide a surgical plane of anesthesia. Which, of course, we've already talked about that you cannot do with midazolam no matter how much you give. But if you're talking about just inducing unconsciousness, then the normal therapeutic dose is approximately, for an 80-kilogram individual, 30 milligrams and up to 50 milligrams. And so it's about 10 to 15 times the normal therapeutic dose, not 100 times the therapeutic dose.

Q. So midazolam can render an individual unconscious but would not be able to maintain that level of unconsciousness. Is that what you're saying?

A. That is correct.

Q. So if 500 milligrams of midazolam is administered with—inconsistent with this lethal-injection protocol, would that render a person unconscious and insensate for the remainder of the execution?

A. I do not believe that it would and the number of executions that have occurred with reported movements after the midazolam has been administered would suggest that it doesn't [126] work in humans when—in that way. That is, it will not keep you insensate and immobile in the face of other noxious stimuli.

Q. And you use the term "noxious stimuli." What does that mean?

A. Anything that is disconcerting to the brain. That can be everything from air hunger from rising carbon dioxide levels after vecuronium is given to the pain of the potassium chloride injection.

Q. If the vecuronium bromide were administered properly, after the midazolam were given, would people be able to see any movement if the prisoner was, in fact, feeling pain from the administration of potassium chloride?

A. No, they would not. And that's why the use of muscle relaxant is actually disallowed in animal euthanasia because it provides a false sense of security and prevents people from seeing whether or not that surgical plane of anesthesia is still maintained.

Q. Would you agree with the statement that when midazolam is used as specified in Chart D the prisoner would quickly reach an unconsciousness and unresponsive state and would not react to painful stimuli?

A. I do not agree with that.

Q. And why is that?

A. Because patients on whom large doses of midazolam have [127] been tested do respond. We've seen that, like I said, in other executions. But the drug was not approved by the FDA as a sole anesthetic because after the use of fairly large doses that were sufficient to reach the ceiling effect and produce induction of unconsciousness, the patients responded to the surgery.

Q. And would you agree or disagree with this statement: The proper administration of 500 milligrams of midazolam in Chart D makes it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from application of the second and third drugs.

A. I disagree. The ceiling effect for midazolam, as we've pointed out, has been clearly established in both animal and human models. And giving more of the drug does not equate with a deeper effect.

Q. Let's talk about note 7, number 7 in Dr. Evans' report that's on the last page of his report that's labeled "Involuntary Movements."

A. Okay.

Q. Have you reviewed that section?

A. I have.

Q. Okay. And have you had the opportunity to look at the article that he cites regarding brain death?

A. I have.

* * * *

[130] would not be able to see these fine motor movements; is that correct?

A. That is correct.

Q. You, in paragraph 19, reference an execution that happened in Arizona where midazolam was given. Have you reviewed information about that execution?

A. I have.

Q. And what is your opinion about the use of 750 milligrams of midazolam in that execution?

A. Well, I would say that that was unintentional experimental proof that large doses of midazolam do not necessarily kill you, make you guarantee unconsciousness, and that the administration of additional doses do not cause further depression of consciousness or Mr. Wood would have stopped breathing and would have gone into a coma were such large doses actually effective. It basically confirms that there is indeed a ceiling effect in—not only in experimental conditions, in published papers that have been provided, but in the inmates who were receiving large doses.

Q. Does it matter in Mr. Wood's execution if the midazolam was introduced all at once or over a period of multiple doses over a period of time?

A. It doesn't really matter. The drug has a sufficient half life that the effect is cumulative. It doesn't disappear at the same rate that, say,

pentobarbital or thiopental does and [131] so it isn't that much different than if you just gave it all at once.

Q. In paragraph 21 of your report, the last page, you have an opinion about midazolam. And could you just restate that for us and explain your opinion.

A. Sure. Midazolam cannot produce a surgical plane of anesthesia. The FDA has said this. The published papers say this. The experimental results of executions did not go as expected prove this. And that is a requirement before causing undue pain and suffering that attends the second and the third drug. So unlike other drugs that have been used, midazolam cannot produce the depth of anesthesia and unconsciousness that is necessary to reliably render the condemned insensate to the following effects of vecuronium bromide and suffocation and potassium chloride and the burning. So I believe that there is a significant risk of harm to the condemned prisoners by the use of the drugs as described herein.

Q. And your second opinion in that paragraph says it amounts to experimentation on human subjects in vulnerable populations. What do you mean by that?

A. Well, no one has ever used this dose of midazolam to produce a surgical plane of anesthesia. They've never been able to reliably produce a surgical plane of anesthesia. And so there is a hypothesis by the state that giving huge doses will produce a surgical plane of anesthesia that's necessary to [132] follow up with the next two drugs.

The definition of experimentation is having a hypothesis and trying it out. And that seems to be what is occurring here because the data, which include the careful modeling showing that there is a ceiling effect of midazolam, its known mechanism of action,

and the proof that it cannot produce electrical silence, even in large doses, would suggest that that hypothesis is false. Yet we're trying it out nonetheless and obviously vulnerable populations or populations that are not at—cannot, at will, refuse to be experimented upon. And it is considered unethical to conduct experimentation on human beings who cannot give their consent to that experimentation.

Q. Thank you. Is it your opinion that to determine consciousness, part of that determination includes noises coming from the person, either speech, speaking? Is that part of what—how you determine whether somebody is conscious or not?

A. It is.

Q. And so if a microphone in the execution chamber were turned off and witnesses were unable to hear attempts to speak, would that affect the ability to, I guess, report whether somebody is conscious or not?

A. It would.

Q. And last question. Would you administer lidocaine to a patient who was unconscious if you were setting a femoral IV

* * * *

[CROSS EXAMINATION]

[135] an excellent drug that reliably produces amnesia to the events following the administration of the drug in terms of long-term recall if used appropriately. And it reduces, like I said, butterflies in one's stomach.

Q. So the only use you use it for, then, is removal of anxiety. Is that what your testimony is?

A. Right now? Yes.

Q. Well, when you say "right now," did you previously use it for other things?

A. Yes. I used it for induction on other occasions and it was not really a suitable drug.

Q. When was the last time you used it for that induction, Doctor?

A. Oh, a long time ago. More than ten years ago.

Q. Did the patient awaken during the procedure, Doctor?

A. Well, I would never—I'm sorry, you misunderstood me. The drug would never be used and has never been used as a sole anesthetic to give anesthesia during a surgery. Not ever. It has been used as an induction of unconsciousness before the administration of other drugs that are sufficient for anesthesia. What it has been used for is just to basically get the patient off to sleep so that you can then either do—do some minor procedures.

The place where the drug is most often used to—is, as I've said, and is indicated for things that don't have a great [136] deal of noxious stimuli, painful stimuli, like colonoscopies. But even then, they usually combine midazolam with some narcotic because the midazolam is usually insufficient.

Q. Isn't also one of the considerations for using an analgesic, though, Doctor, that you're performing a surgical procedure and the patient is going to be later brought back to consciousness to resume their lives. I mean, isn't that an anticipation?

A. You're using it because otherwise the patient would respond and potentially wake up. It has nothing to do with waking them up after the surgery. You're concerned about them waking up in the middle of

surgery. It's not an appropriate drug. It's not approved by the FDA. It is not used by any anesthesiologist as the sole drug to deliver a surgical plane of anesthesia, which, as I've said, is a requirement for euthanasia of animals.

Q. Okay. So you're talking a surgical plane of anesthesia when you're talking about induction of anesthesia in your report. Is that what you're saying?

A. No, that is not what I'm saying. So, once again, induction of anesthesia is merely getting a patient off to sleep. A surgical plane of anesthesia is maintaining unconsciousness and maintaining the patient insensate and immobile to the painful stimuli that will follow.

Q. Okay. So it's your belief that in an execution a surgical [137] plane of anesthesia needs to be attained and maintained. Is that your testimony?

A. That is correct.

Q. Doctor, you testified a little bit earlier—

A. Well, excuse me. Excuse me. I—excuse me. I don't—I want to make this really clear. I'm not—I'm not telling you how you should perform an execution. What I am saying is that if you do not have a surgical plane of anesthesia during an execution, the condemned is likely to suffer or potentially could suffer egregious harm from the administration of the next drugs.

Q. In your opinion, correct, Doctor?

A. Sure.

Q. Okay. Ceiling effect, you talked about that a little bit earlier. Can you tell me approximately where

that occurs? At what point do you no longer receive benefit from midazolam?

A. Probably after about 40 milligrams, 40 to 50 milligrams. I'd have to check the specific studies that defined the ceiling effect in terms of plasma levels and equate that back to bolus dosing. That would take some time and calculations. So I don't want that to be an absolute answer.

Q. So you can't, as you sit here today, tell us where the ceiling effect is; is that correct?

A. No, I can tell you where it is related to blood levels by referring to a couple of the papers. I just can't equate it to [138] the dosing that is being delivered in an execution.

Q. Okay. So you're saying you can tell us? If you can, I would like to know what it is, Doctor.

A. I understand. I said I can't tell you right now. I can calculate it and come back with an answer, but I can't do it at the moment. It requires a complex calculation working backwards from plasma levels to administration to volume of distribution to the time between the injection and those measurements are taken. It's not an easy calculation.

Q. Okay. Doctor, you also said that you reviewed Attachment D to the current protocol in Oklahoma; is that correct?

A. Yes. Can you refer which exhibit you're referring to, please?

MR. HADDEN: I don't have plaintiffs' exhibit numbers. Do you know what that is?

MS. KONRAD: Sixty-eight.

Q. (BY MR. HADDEN) Sixty-eight.

A. So I have—I have the Exhibit 68. Which—what attachment are you referring to?

Q. It's called Attachment D at the top. It says Preparation and Administration of Chemicals. Is that the right one?

A. Yes.

Q. Okay.

A. Yes, I have that.

Q. If you would turn then to page 2 and just look for me at [139] Charts A and B. Are you saying that you don't have a problem with Charts A or B?

A. I am not going to comment on whether or not an execution protocol is or is not appropriate. I can tell you that the use of sodium thiopental has been shown, through scientific research that I have performed, may be insufficient to render a patient unconscious through the entirety of the execution. That much I can tell you. Anything further would be a breach of my ethics to comment specifically about protocols and their construct.

Q. Okay. But earlier when you were asked some questions you were kind of going back and forth between barbiturates and why they were so much better than benzodiazepines. And I thought what you said in there was that barbiturates work a lot better and don't have a ceiling effect and can achieve a surgical plane of anesthesia. Is that correct?

A. That's what I said, that is correct.

Q. Okay. So without considering these charts, Doctor, considering if we just said a hypothetically 200-pound man, how much pentobarbital would we

need to give that individual to obtain a surgical plane of anesthesia?

A. As I've said, it is not my place to inform the state how to perform an execution, and I will respectfully decline to answer that. It is a formal breach of ethics as defined by both the American Society of Anesthesiology and the American [140] Medical Association. I can only comment on whether or not the protocols are likely to produce egregious harm and suffering. And I believe they all are actually constructed to produce egregious harm and suffering and have testified as such in other places. My testimony is on record in that regard about the use of thiopental.

Q. Okay. And at least in the case of Florida, your testimony was disregarded and it was found to be constitutional, correct?

A. I don't believe my testimony was disregarded.

Q. It was found constitutional against your testimony, correct, Doctor?

A. The judge made a ruling that absent evidence that what I said was more valid than what Dr. Evans said, he was not going to change things. In the intervening time, there have been a number of executions where the use of midazolam has found to be faulty. And I believe that given that evidence, the judge might rule differently today.

Q. I see. So—

A. That's my opinion.

Q. —in Florida, they've had complications that have required the Court to reverse it? Is that what you're saying?

A. They have not reversed it yet, but they have experienced problems with the executions.

Q. Okay. They currently do have a twelfth execution scheduled, though, don't they, Doctor?

* * * *

[144] Q. Okay. You had also testified about paradoxical effect. Do you remember some of those questions, Doctor?

A. Sure.

Q. Okay. Some of the descriptions you gave of what you would see in paradoxical effect sounds as if they would be fairly obvious. Is that fair to say that, Doctor?

A. Sometimes they're obvious, sometimes they're not obvious. The descriptions of paradoxical reactions are many and they cover a broad gamut of presentations including specific case reports that document apparent sedation followed by paradoxical reactions.

Q. Okay. Doctor, just so I'm clear, your testimony is that an IV induction of 500 milligrams of midazolam could not achieve either a surgical plane of anesthesia or a coma; is that correct?

A. That is correct. Well, not reliably. That's a very important point. People have a large range of reactions to all drugs. The question is whether something will do something reliably, which I think is important when you're introducing extremely painful and dilatory substances to follow.

Q. So what are we saying reliably? Are we saying 5 percent, 2 percent? What are we saying?

A. Well, in healthy individuals, in dose-ranging studies that go up to the ceiling effect, there is no EEG

silence reported in humans. So you want me to say "never." But, again, because

* * * *

[REDIRECT]

[150] take a needle with a little plastic sheath over it and they find a vein and they insert the needle into the vein and the plastic sheath—they leave the plastic sheath in and they pull out the needle. It's the exact same thing in a femoral line except for the fact you can't really see the femoral vein. The femoral vein is buried deep, usually a couple of inches below the skin's surface.

And so in preparing for a femoral line, there are a couple of issues. One is, you're going to be digging deeper into the tissue, so the use of lidocaine, if someone is not unconscious, would be highly recommended. And number two is that you would use a longer than normal IV catheter. That wasn't done in this case. And, again, begs the question of competency. And third and not least is the fact that it can be infected. Of course, you're not worried about that with an execution. But it can be infected and so you would—when you're prepping for a femoral line, you're usually putting Betadine or alcohol around the area because the groin is not a sterile arena in which to practice a sterile procedure.

THE COURT: Thank you. Any redirect?

REDIRECT EXAMINATION

BY MS. KONRAD:

Q. Just a few questions, Dr. Lubarsky. I feel like I've asked these a couple of times, but I want to make sure that your opinion is clear for the record. We talked about the [151] execution in Arizona of Joseph

Wood and opposing counsel asked if this was the same drugs that are called for in Oklahoma's execution and you said no. What is the significance of the use of 750 milligrams of midazolam in Mr. Wood's execution to your opinion?

A. It suggests that the 100 or 500 that might be used in Oklahoma now is not reliably going to be effective to produce the desired effect of a deeply unconscious state that is maintained at a surgical plane of anesthesia.

Q. And you mentioned that—you say "we," I guess the community, the medical community knows that midazolam is not used for surgical anesthesia and you said when—we know that from when the drug was being studied and introduced. Can you explain that?

A. Yes. In the original landmark review article published in 1985 by Reeves, et al, it was very clear that they stated that the drug was—had failed when it was used as both an induction and maintenance agent in terms of blunting the effects of surgery. And so people didn't use it and the FDA didn't approve it for that indication.

Q. So there was research done to support the fact this drug could not reach a level of anesthesia that's necessary when you're doing surgery?

A. That is correct.

Q. And Mr. Hadden mentioned a consciousness check. And if [152] one is unconscious at the consciousness check under Oklahoma's protocol after five minutes, if a physician or other personnel deems the person unconscious, is that sufficient to protect against painful and noxious stimuli that would be introduced through the second and third drug?

A. No, it is not sufficient.

Q. And why is that?

A. Because the whole concept of consciousness is about the balance of depressing things such as medications and awakening things such as a variety of different stimuli including pain and air hunger. And so you could be unconscious and not reacting to minor stimuli, but when major stimuli such as are represented by the introduction of the next two drugs come into play, you are jolted into consciousness and you are quite aware and you wake up. And that is—that's why, again, if producing anesthesia for prolonged periods of time were easy, it wouldn't take three years of study. The whole idea of balancing the administration of drugs to the level of painful or annoying stimuli and giving a patient just enough but not too much so that they maintained a surgical plane of anesthesia is an art form. It cannot be simulated in a dry run by people without suitable education.

MS. KONRAD: Thank you.

THE COURT: Any recross?

MR. HADDEN: Just one.

Declaration of David A. Lubarsky, M.D., M.B.A.

I, David A. Lubarsky, do hereby declare the following to be true and correct to the best of my knowledge under the penalty of perjury:

1. I am an anesthesiologist and have provided my opinion as an expert witness in *Warner v. Gross*, No. 5:14-cv-00665-F (W.D. Okla.). I testified on December 17, 2014, at the preliminary injunction hearing in that case.

2. I was not present for the testimony of R. Lee Evans, Pharm.D. I have, however, reviewed the transcript of Dr. Evans' testimony. This document was provided to me late in the evening on December 22, 2014. Due to the holiday, I was unable to review the transcript until December 29.

3. I have been asked to provide my opinion regarding Dr. Evans' testimony specifically with regard to his statements about the effects of midazolam on the spinal cord and brain.

4. Dr. Evans' testimony is wrong about the facts regarding the mechanism of action of midazolam via GABA. Textbooks are in agreement with my testimony that GABA is an inhibitory substance for brain activity, and its inhibition of brain activity is accentuated by midazolam (Vuyk, Sitsen & Reekers, 2015). His statements that midazolam inhibits GABA is factually incorrect—opposite to scientific fact.

5. Dr. Evans' testimony demonstrates that he is wrong about the facts of where general anesthetics primarily produce anesthesia (*unconsciousness*). This occurs via the

suppression of the cerebral cortex and most likely the reticular activating system which is involved in consciousness. The spinal cord is not considered by any authoritative publication the primary site of anesthetic action, although it may contribute indirectly to anesthetic action and influence immobility during an anesthetic state (Perouansky, Pearce & Hemmings, 2015). Dr. Evans provides no scientific evidence to support his erroneous statements.

6. Despite Dr. Evans' assertions to the contrary, the ceiling effect is scientifically proven as fact and does not occur at the spinal cord level, nor has it been extensively studied there. Primary modes of anesthetic action of midazolam occur in the brain (Perouansky, Pearce & Hemmings, 2015) where electrical activity (*the basis of consciousness and human and animal awareness*) is not further diminished with larger doses.

   Specifically, in one of the only human studies on the ceiling effect, the maximum effect of midazolam on the brain is described in J Clin Pharmacol 2004;44:605-611. It shows that midazolam reaches its maximal effect on brain activity after a dose of approximately 0.3mg/kg (*dose used for induction of unconsciousness in the absence of noxious stimuli*). The effect on the brain does not appreciably increase with increasing doses. This was studied up to double the induction dose, and there is no scientific evidence or scientific theory in existence that would suggest additional doses (*such as Oklahoma's dose of 500mg*) would have any further effect. This is consistent with the definition of a ceiling effect. The repetitive high

dosing to a total of 750mg of midazolam (*during the Arizona execution of Joseph Woods*) without causing cessation of breathing is also consistent with the ceiling effect. This is equally consistent with the FDA's conclusion that midazolam cannot be used as a sole anesthetic as it does not reliably prevent consciousness and responsiveness when used as a sole drug in the presence of noxious (*surgical*) stimuli. Dr. Evans' offers his opinion about the lack of a ceiling effect without any scientific evidence to contradict the objective, published data cited here or the conclusions of the FDA that takes into account all published and unpublished data from clinical trials.

The ceiling effect was also clearly demonstrated in a dog study and the presence of a ceiling effect is specifically referenced in the conclusions. The study concludes that midazolam cannot fully provide the surgical plane of anesthesia required for surgery, even with Oklahoma's proposed 500mg dose (*based on a tail clamp test as a surrogate for surgical stimuli*). This is consistent with the FDA approved use of the drug as an adjunct but not as a sole agent for general anesthesia. *See* Hall RI, Schwieger IM, Hug CC Jr., The anesthetic efficacy of midazolam in the enflurane-anesthetized dog, 1988 Jun; 68(6): 862-6, http://www.ncbi.nlm.nih.gov/pubmed/3377232.

7. On page 636 of his testimony, Dr. Evans describes "the reticular activating system, the part of the brain that controls respiration." This is also factually incorrect. The reticular activating center has nothing to do with

respirations; other parts of the brainstem primarily control respirations. The reticular activating system is primarily involved in wakefulness/consciousness-unconsciousness. *See* Chokroverty & Avidan, 2012, Haines & Mihailoff, 2013 and Shingu & Nakao, 2015.

8. Also on page 636 of his testimony, Dr. Evans discusses a ceiling effect and describes it as an effect "specifically on the spinal cord" and he states "there are studies to show that, you know, you can eliminate a significant portion of an inhaled anesthetic with the use of midazolam, but you can't completely eliminate it, and that's really to maintain a plane of surgical - a surgical plane, and that's all at a spinal cord level." Dr. Evans provides no scientific evidence to support his erroneous statement; neither anesthesia itself, nor midazolam mechanism of action, or its ceiling effect are primarily acting at the spinal cord level (Perouansky, Pearce & Hemmings, 2015 and Vuyk, Sitsen, & Reekers, 2015). The only study known to have looked at reducing inhaled anesthetics using midazolam as a substitute is Hall et al. cited above in paragraph 6, and it does not discuss actions at the spinal cord and contradicts Dr. Evans' testimony.

9. As a practicing anesthesiologist for a quarter of a century, and Chair of one of the largest training programs in the country at the Department of Anesthesiology at the University of Miami Miller School of Medicine, I assert that Dr. Evans' opinions are not scientifically valid, and given his many factual mistakes, dispute his ability to serve as an expert about a field of medicine he does not practice and in which he was never

trained. He would not qualify for a license to administer anesthesia in any jurisdiction of the United States.

I hereby declare the foregoing to be true and correct to the best of my knowledge under the penalty of perjury.

Executed this 8 day of January, 2015.

/s/ David A. Lubarsky
David A. Lubarsky, M.D., MBA

References

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2. Greenblatt, D.J., Ehrenberg, B.L., Culm, K.E., et al. Kinetics and EEG effects of midazolam during and after one-minute, one-hour, and three-hour intravenous infusions. *J Clin Pharmacol* 2004; 44:605-611.
3. Hall, R.I., Schwieger, I.M. & Hug, C.C. (1988). The anesthetic efficacy of midazolam in the enflurance-anesthetized dog. *Anesthesiology*; 1988 Jun; 68(6):862-6.
4. Haines, D.E., & Mihailoff, G.A. (2013). An overview of the brainstem. In D. E. Haines, et al. (Eds.), *Fundamental Neuroscience of Basic and Clinical Applications, Fourth Edition* (pp. 138-145). Philadelphia, PA: Saunders.
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6. Shingu, K. & Nakao, S. (2015). Neurophysiologic basis of brain death: arousal and consciousness. In R. D. Miller, et al. (Eds.), *Miller's Anesthesia, Eighth Edition* (pp. 2307-2327.e3). Philadelphia, PA: Saunders.
7. Vuyk, J., Sitsen, E. & Reekers, M. (2015). Intravenous anesthetics: effects on the central nervous system. In R. D. Miller, et al. (Eds.), *Miller's Anesthesia, Eighth Edition* (pp. 821-863 .e9). Philadelphia, PA: Saunders.

EXPERT REPORT OF LARRY D. SASICH, PHARMD, MPH, FASHP

RE: *Charles F. Warner, et. al., v. Gross, et. al., No. CIV-14-665F*

November 26, 2014

REPORT OF LARRY D. SASICH, PHARMD, MPH, FASHP

My name is Larry D. Sasich. I am a consultant pharmacist with experience in pharmacy practice, academia, public interest research, drug regulation, and drug safety.

My background, experience and qualifications, in part, include:

- Serving as Chairperson of the Department of Pharmacy Practice at the LECOM School of Pharmacy in Erie, Pennsylvania.
- Serving as a consultant to Public Citizen Health Research Group, Washington, D.C.
- Serving as a Consumer Representative on the Science Board of Food and Drug Administration, an advisory committee to the FDA Commissioner.
- Serving as a consultant to the Saudi Food and Drug Authority, Riyadh, Saudi Arabia.

I have a Masters in Public Health, with an emphasis in biostatistics and epidemiology, from The George Washington University, and a Doctorate of Pharmacy degree from University of the Pacific. I completed a residency in nuclear pharmacy at the University of

New Mexico. I have also been elected a Fellow in the American Society of Health-System Pharmacists (FASHP). I have authored publications and/or presented analysis on drug safety issues. A complete list of my publications and presentations are listed in my Curriculum Vitae, which is appended to this Report as Exhibit 1, and contains a list of all publications I have authored in the previous ten years.

During the previous four years, I have testified as an expert in *Hill v. Owens, et al.*, 2013cv233771 (Super. Ct. Fulton Cty., Ga.), and in *Sepulvado v. Jindal*, 3:12-cv-00796 (M.D. LA).

I have been retained by counsel for Plaintiffs in *Warner v. Gross*, No. 5:14-cv-00665-F, to provide my opinion on the use of midazolam, vecuronium bromide, and potassium chloride in Oklahoma's execution procedures. I have been asked to provide my opinion regarding the safety and risks of administering midazolam as an anesthetic in executions, and to discuss whether it has any analgesic properties, whether it has a ceiling effect, and whether it has risks of paradoxical reactions. I have also been asked to consider whether Oklahoma's increase of the midazolam dosage from 100 mg to 500 mg intravenously in the lethal-injection protocol would ameliorate risks that an individual would be subjected to significant pain and suffering before death.

I am being compensated at the rate of $300.00 per hour for my review and testimony in this case. To date, I have billed $1,200.00.

Sources of the facts and data I have considered in forming my opinions are

1. The Oklahoma Department of Public Safety – The Execution of Clayton D. Lockett (Executive Summary)
2. Procedures for the Execution of Offenders Sentenced to Death, Anita Trammel, Warden, Oklahoma State Penitentiary. Effective April 14, 2014.
3. Attachment D, to Procedures for the Execution of Offenders Sentenced to Death, Robert Patton, Director, Oklahoma State Penitentiary. Effective September 30, 2014.
4. The current US Food and Drug Administration (US FDA) approved professional product labels for midazolam, vecuronium bromide, and potassium chloride (attached to this Report as Exhibits 2, 3, and 4).
5. Transcripts of interviews with David Autry, Ziva Branstetter, Redacted Name #7, and Commissioner Mike Thompson.
6. Published literature as cited within this Report.

According to the Oklahoma Department of Public Safety's Executive Report, Mr. Lockett's execution team had difficulty in establishing vascular access in sites routinely used to administer IV drugs. Access was eventually established in the right femoral vein. Midazolam was administered. According to reports, the full dose of midazolam 100 mg (20 ml) was administered. Five minutes after the beginning of the administration of midazolam, a physician declared that Mr. Lockett was still conscious. Seven minutes after the beginning of the administration of midazolam, a physician declared that Mr. Lockett was

unconscious. Then, vecuronium bromide was administered followed by potassium chloride. According to the State's report, 90% of the potassium chloride was administered.

Mr. Lockett began to move and make sounds approximately three minutes after the Warden signaled for the vecuronium bromide to be administered. The movement continued for approximately six minutes before the blinds were drawn, and continued after the blinds were drawn. A Department of Corrections' employee described Mr. Lockett's movements after the blinds were drawn, and said that he had to hold down Mr. Lockett's shoulder so Mr. Lockett would not buckle. According to the Executive Summary, at some point during the execution the IV line infiltrated. Mr. Lockett was pronounced dead 43 minutes after the execution began.

Based on my expertise and background as well as my review of the documents as stated above, I offer the following opinions:

I. Midazolam

Midazolam is a benzodiazepine drug for injection that is FDA approved for:

- Intramuscular (IM) or intravenous (IV) for preoperative sedation/anxiolysis/amnesia;
- IV for sedation/anxiolysis/amnesia, either alone or in combination with other Central Nervous System depressants, prior to or during diagnostic, therapeutic or endoscopic procedures, such as bronchoscopy, gastroscopy, cystoscopy, coronary angiography, cardiac catheterization, oncology procedures,

radiologic procedures, suture of lacerations and other procedures;

- intravenously for induction of general anesthesia, before administration of other anesthetic agents.
- continuous intravenous infusion for sedation of intubated and mechanically ventilated patients as a component of anesthesia or during treatment in a critical care setting.[1]

Midazolam is a short-acting benzodiazepine central nervous system (CNS) depressant with a rapid onset of action. When given IV, sedative effects occur in 3 to 3.5 minutes. The time to onset of sedative effects after IM administration in adults is 15 minutes, with the peak effect occurring 30 to 60 minutes after injection.

There are three main reasons midazolam is an inappropriate choice to use as the anesthetic drug in Oklahoma's execution procedure: It has no analgesic effect; it has a ceiling effect; and it can cause a paradoxical reaction.

A. Lack of Analgesic Effect

Midazolam has no analgesic (i.e., pain relieving) effect. The absence of an analgesic effect for midazolam similar to that of the opioids has been recognized for years.[2]

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[1] Akom, Inc. Professional Product Label – Midazolam Injection, July 2012. At http://dailymed.nlin.nih.govidaily med/drugInfo.cfm?setid=737361a0-861-4d3c-ba5e-44df3f49fa22. Accessed November 21, 2014.

[2] Reves JG, Fragen R.1, Vinik HR, Greenblatt DJ. Midazolam: pharmacology and uses. Anesthesiology. Mar 1985;62(3):310-324.

In fact, studies have shown that midazolam increases the perception of pain. Gamma amino butyric acid (GABA) receptor agonists such as midazolam have been shown to enhance pain. An agonist is a drug that binds to receptors on cells and activates the receptor to produce a biological response. Recent research rated experimental pain from cold, heat, and restricted blood supply or electrical sources before and during moderate sedation with midazolam. Midazolam increased cold, heat and electrical pain perception significantly on a 10-point pain rating scale.[3]

B. Ceiling Effect

At low doses, the benzodiazepines, including midazolam, are expected to have anxiolytic and anticonvulsive effects. As the dose increases, the benzodiazepines are expected to produce sedation, amnesia, and finally lack of response to stimuli such as pain (unconsciousness). While the effect of the benzodiazepines is clearly dose-related, the literature indicates that there is a ceiling beyond which increasing the dose does not increase the effect.[4] In practical terms, more is not necessarily better.

The use of midazolam to render a person unconscious and unable to sense the painful effects from the drugs vecuronium bromide and potassium chloride has not been subjected to scientific testing. I was unable to determine the midazolam dose for a ceiling

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[3] Frölich MA, Zhang K, Ness T. Effect of Sedation on Pain Perception. Anesthesiology 2013; 118(3):611-621. doi:10.1097/ALN.0b013e318281592d.

[4] Saari TI, Uusi-Oukari M, Ahonen J, Olkkola KT. Enhancement of GABAergic activity; neuropharmacological effects of benzodiazepines and therapeutic use in anesthesiology. Pharmacol Rev. Mar 2011;63(1):243-267.

effect on unconsciousness because there is no literature in which such testing has been done.

C. Paradoxical Reaction

The professional product label for midazolam warns of paradoxical reactions:

> Reactions such as agitation, involuntary movements (including tonic/clonic movements and muscle tremor), hyperactivity and combativeness have been reported in both adult and pediatric patients. These reactions may be due to inadequate or excessive dosing or improper administration of midazolam; however, consideration should be given to the possibility of cerebral hypoxia or true paradoxical reactions.

A precise incidence or risk of any adverse drug including paradoxical reactions with midazolam – as with most drugs – is unknown. No national adverse drug reaction reporting system is capable of detecting all of the reactions that occur with a drug. There is no system available to know with accuracy the number of patients who have actually used a drug. Without these two pieces of information, the *precise* risk or incidence of adverse drug reactions cannot be calculated. However, the medical literature contains numerous reports of paradoxical reactions to benzodiazepines in adults.[5] Some reports estimate that that paradoxical reactions vary from 1% to above 10%.[6]

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[5] Mancuso CE, Tanzi MG, Gabay M. Paradoxical reactions to benzodiazepines: literature review and treatment options. Pharmacotherapy. Sep 2004;24(9):1177-1185.

[6] Shin YH, Kim MH, Lee JJ, et al. The effect of midazolam dose and age on the paradoxical midazolam reaction in Korean pediatric patients. Korean J Anesthesiol. Jul 2013; 65(1):9-13.

There are published case studies supporting that a paradoxical reaction can occur after a person is adequately sedated.[7] After initial sedation with midazolam in response to surgical manipulation, one patient experienced a paradoxical reaction to midazolam. As the total dose of midazolam increased, symptoms of the paradoxical reaction became worse.

A 27-year-old male was initially given 2 mg of midazolam IV prior to examination of his bladder and urethra. Several minutes after starting the procedure he became agitated, anxious, and restless. An additional 5 mg of midazolam was given over the next 10 minutes with no improvement in symptoms. Upon arrival in the post-op area he continued to be restless and agitated. Lorazepam, also a benzodiazepine, was given in a 4 mg dose with no changes in his symptoms, Four minutes after giving flumazenil, a drug used to reverse the effects of benzodiazepines, his symptoms stopped and he fell asleep.[8]

There is also literature that certain populations might be more at risk for the paradoxical effect, i.e. history of aggressive or impulsive behaviors, history of drug or alcohol abuse, history of psychiatric disorders.

II. Vecuronium Bromide

Vecuronium bromide is classified as a non-depolarising neuromuscular blocking agent. The drug is approved for IV use only as an adjunct to general anesthesia, to facilitate endotracheal intubation and

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[7] Rodrigo. CR. Flumazenil Reverses Paradoxical Reaction with Midazolam. Anesth Prog. 1991; 38:65-68.

[8] Thurston TA, Williams CG, Foshee SL. Reversal of a paradoxical reaction to midazolam with flumazenil. Anesth Analg. Jul 1996; 83(1):192.

to provide skeletal muscle relaxation during surgery or to mechanically assist breathing.[9]

There are two main types of neuromuscular blocking agents:

1. Depolarising. These first stimulate contraction of muscles by their action at the neuromuscular junction and then produce paralysis.
2. Non-depolarising. By contrast, these drugs do not cause any muscle activity before relaxation. These are competitive Mockers at the acetylcholine receptors on the neuromuscular junction. Competitive Mockers means that the effect can be reversed by drugs that increase acetylcholine. Vecuronium is an example of a non-depolarising agent.

The drug is approved for IV use only for surgical procedures and mechanical ventilation or breathing. These procedures are performed in hospitals under close monitoring. Examples of vecuronium bromide infiltration could not be found in the literature.

According to reports, 40 ml of vecuronium bromide was administered during the execution of Mr. Lockett. Based on various accounts of the execution, Mr. Lockett was not paralyzed after the vecuronium bromide was administered, as he began to move and speak at some point during the administration of potassium chloride. The IV had infiltrated at some point, and Mr. Lockett may have been experiencing the suffocation from the slow absorption of the

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[9] Sagent Pharmaceuticals, Inc. Professional Product Label Vecuronium Bromide, July 2011. At http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d3b851af-f8e9-4375-bbbe7132e66ee0d0. Accessed November 22, 2014.

vecuronium bromide into tissue, or may have been experiencing pain from the drug itself. The pH of a typical product is adjusted to the acid side, pH 3.5 to 4.5. The signs and symptoms of IV infiltration include swelling, discomfort, and burning. This volume of an acidic solution may have caused Mr. Lockett pain and discomfort.

III. Potassium Chloride

Potassium-containing solutions are intrinsically irritating to tissues. Therefore, extreme care must be taken to avoid infiltration. Local tissue necrosis (death) and subsequent sloughing may result if extravasation occurs. Chemical inflammation and spasm of veins have also been reported.

Should infiltration occur, administration should be discontinued immediately. Local infiltration of the affected area with procaine hydrochloride, 1%, to which hyaluronidase may be added, will often reduce venospasm and dilute the potassium remaining in the tissues locally. Local application of heat may also be helpful.

Based on reports I have reviewed, Mr. Lockett was administered an estimated 90 ml of his 100 nil dose of potassium chloride. Mr. Lockett would have experienced severe pain from the infiltrated potassium chloride. I am not aware of any actions that were taken to minimize or alleviate the severe pain that Mr. Lockett would have experienced from the potassium chloride hi his tissue.

IV. Conclusion

The Oklahoma Department of Public Safety Executive Summary of Mr. Lockett's execution describes IV infiltration at the access site in the right groin. The

physician present at the execution believed that the drugs were being absorbed into Mr. Lockett's tissue, although it is not certain when the infiltration began. Drugs that infiltrate into surrounding tissue enter the blood stream and distribute at a slower rate than if given directly into a vein.

At least four possibilities arise as to why Mr. Lockett began to move and talk after midazolam was administered and the physician declared Mr. Lockett to be "unconscious." One, midazolam is not an analgesic and therefore as the IV fluids continued to infiltrate, he was aroused and began to move and talk in response to pain. Two, Mr. Lockett experienced a paradoxical reaction to midazolam. Three, Mr. Lockett reacted to a combination of pain caused by drug infiltration (either vecuronium bromide or potassium chloride or both) and a paradoxical reaction to midazolam. Four, Mr. Lockett may have reacted to the awareness of the beginning of suffocation by paralysis from the vecuronium bromide itself Moreover, the onset of IV vecuronium bromide is approximately three minutes. Mr. Lockett could not have received an adequate dose of this drug, as he was able to move and speak.

I could find no evidence to suggest that a 500 mg dose of midazolam rather than 100 mg would have prevented the events Mr. Lockett suffered. Because of midazolam's chemical properties (including having no analgesic effect and having a ceiling effect), and because midazolam can produce a paradoxical reaction, it is not an appropriate drug to use when administering a paralytic followed by potassium chloride. The pain suffered by Mr. Lockett could potentially be suffered by others, but if the paralytic is

properly administered, it would prevent the condemned prisoner from being able to outwardly express pain.

I reserve the right to change my opinion should any additional information become available and be provided to me.

Dated: November 26, 2014

Signed: /s/ Larry D. Sasich
Larry D. Sasich

EXHIBIT 2

MIDAZOLAM - midazolam hydrochloride injection
Akorn, Inc.

Midazolam Injection, USP
Rx only
CIV
WARNING

***Adult and Pediatric*: Intravenous midazolam has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings. In some cases, where this was not recognized promptly and treated effectively, death or hypoxic encephalopathy has resulted. Intravenous midazolam should be used only in hospital or ambulatory care settings, including physicians' and dental offices, that provide for continuous monitoring of respiratory and cardiac function, i.e., pulse oximetry. Immediate availability of resuscitative drugs and age- and size-appropriate equipment for bag/valve/mask ventilation and intubation, and personnel trained in their use and skilled in airway management should be assured. (see WARNINGS.) For deeply sedated pediatric patients, a dedicated individual, other than the practitioner performing the procedure, should monitor the patient throughout the procedure.**

The initial intravenous dose for sedation in adult patients may be as little as 1 mg, but should not exceed 2.5 mg in a normal healthy adult. Lower doses are necessary for older (over 60 years) or debilitated

patients and in patients receiving concomitant narcotics or other central nervous system (CNS) depressants. The initial dose and all subsequent doses should always be titrated slowly; administer over at least 2 minutes and allow an additional 2 or more minutes to fully evaluate the sedative effect. The use of the 1 mg/mL formulation or dilution of the 1 mg/mL or 5 mg/mL formulation is recommended to facilitate slower injection. Doses of sedative medications in pediatric patients must be calculated on a mg/kg basis, and initial doses and all subsequent doses should always be titrated slowly. The initial pediatric dose of midazolam for s edation/anxiolys is /amnesia is age, procedure, and route dependent (see DOSAGE AND ADMINISTRATION for complete dosing information).

Neonates: Midazolam should not be administered by rapid injection in the neonatal population. Severe hypotension and seizures have been reported following rapid IV administration, particularly with concomitant use of fentanyl (see DOSAGE AND ADMINISTRATION for complete information).

DESCRIPTION

Midazolam hydrochloride is a water-soluble benzodiazepine available as a sterile, nonpyrogenic parenteral dosage form for intravenous or intramuscular injection. Each mL contains midazolam hydrochloride equivalent to 1 mg or 5 mg midazolam compounded with 0.8% sodium chloride and 0.01% disodium edetate, with 1% benzyl alcohol as preservative; the pH is adjusted to 3.3 to 3.5 with hydrochloric acid and, if necessary, sodium hydroxide.

Midazolam is a white to light yellow crystalline compound, insoluble in water. The hydrochloride salt of midazolam, which is formed *in situ*, is soluble in

aqueous solutions. Chemically, midazolam HC1 is 8-chloro-6-(2-fluoro-pheny1)-1-methyl-4H-imidazo[1,5-a] [1,4]benzodiazepine hydrochloride. Midazolam hydrochloride has the molecular formula C18H13C 1FN3 -HC1, a calculated molecular weight of 362.25 and the following structural formula:

EXHIBIT 4

Potassium is the major cation of body cells (160mEq/liter of intracellular water) and is concerned with the maintenance of body fluid composition and electrolyte balance. Potassium participates in carbohydrate utilization, protein synthesis, and is critical in the regulation of nerve conduction and muscle contraction, particularly in the heart. Chloride, the major extracellular anion, closely follows the metabolism of sodium, and changes in the acid-base of the body are reflected by changes in the chloride concentration.

Normally about 80 to 90% of the potassium intake is excreted in the urine, the remainder in the stools and to a small extent, in the perspiration. The kidney does not conserve potassium well so that during fasting, or inpatients on a potassium-free diet, potassium loss from the body continues resulting in potassium depletion. A deficiency of either potassium or chloride will lead to a deficit of the other.

INDICATIONS AND USAGE

Potassium Chloride Injection is indicated in the treatment of potassium deficiency states when oral replacement is not feasible.

THIS HIGHLY CONCENTRATED, READY-TO-USE POTASSIUM CHLORIDE INJECTION IS INTENDED FOR THE MAINTENANCE OF SERUM K^+ LEVELS AND FOR POTASSIUM SUPPLEMENTATION IN FLUID RESTRICTED PATIENTS WHO CANNOT ACCOMMODATE ADDITIONAL VOLUMES OF FLUID ASSOCIATED WITH POTASSIUM SOLUTIONS OF LOWER CONCENTRATION.

When using these products, these patients should be on continuous cardiac monitoring and frequent testing for serum potassium concentration and acid-base balance.

CONTRAINDICATIONS

Potassium Chloride Injection is contraindicated in diseases where high potassium levels may be encountered, and inpatients with hyperkalemia, renal failure and in conditions in which potassium retention is present.

WARNINGS

THIS HIGHLY CONCENTRATED, READY-TO-USE POTASSIUM CHLORIDE INJECTION IS INTENDED FOR THE MAINTENANCE OF SERUM K^+ LEVELS AND FOR POTASSIUM SUPPLEMENTATION IN FLUID RESTRICTED PATIENTS WHO CANNOT ACCOMMODATE ADDITIONAL VOLUMES OF FLUID ASSOCIATED WITH POTASSIUM SOLUTIONS OF LOWER CONCENTRATION.

TO AVOID POTASSIUM INTOXICATION, DO NOT INFUSE THESE SOLUTIONS RAPIDLY.

PATIENTS REQUIRING HIGHLY CONCENTRATED SOLUTIONS SHOULD BE KEPT ON CONTINUOUS CARDIAC MONITORING AND UNDERGO FREQUENT TESTING FOR SERUM POTASSIUM AND ACID-BASE BALANCE, ESPECIALLY IF THEY RECEIVE DIGITALIS.

In patients with renal insufficiency, administration of potassium chloride may cause potassium intoxication and life-threatening hyperkalemia.

Administer intravenously only with a calibrated infusion device at a slow, controlled rate. (See DOSAGE

AND ADMINISTRATION.) Because pain associated with peripheral infusion of Potassium Chloride solution has been reported, whenever possible administration via a central route is recommended for thorough dilution by the blood stream and avoidance of extravasation. Highest concentrations (300 and 400 mEq/L) should be exclusively administered via central route.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-665-F

CHARLES F. WARNER, ET AL.

Plaintiffs,

vs.

KEVIN J. GROSS, ET AL.,

Defendants.

TRANSCRIPT OF PRELIMINARY INJUNCTION
HEARING BEFORE THE HONORABLE
STEPHEN P. FRIOT
UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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* * * *

[333] investigation does reflect those events in your opinion, doesn't it?

A. Yes, sir, it does.

Q. In terms of dimensions of the room, you were present when counsel for plaintiffs came down for a site inspection, were you not?

A. I was there, yes, sir.

Q. And did they measure the room at that time?

A. Yes, sir, they did.

MR. HADDEN: No further questions.

THE COURT: You may step down.

We'll have the plaintiffs' next witness.

MS. GHEZZI: We will call Dr. Sasich.

THE COURT: Very well.

LARRY SASICH,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MS. KONRAD:

Q. Good morning, Dr. Sasich.

A. Good morning.

Q. Please state your name for the record.

A. First name Larry, last name Sasich. Spelled S, as in Sam, A, S, as in Sam, I-C-H.

Q. And what is your profession, Dr. Sasich?

A. I'm a pharmacist by education and presently I'm a [334] consultant and I'm also co-founder of Patient Drug News Limited.

THE COURT: Co-founder of what?

THE WITNESS: It's called Patient Drug News Limited. And we are providing USFDA-approved patient drug safety information to the public, not only in English, but in foreign languages. And our first attempt has been—our first—

THE COURT: All I asked was what. Go ahead. Next question.

Q. (BY MS. KONRAD) I'd like to turn your attention to Plaintiffs' Exhibit 77. Does this look like a report that you authored for this case?

A. It does.

Q. And your report included some attached exhibits?

A. Yes.

Q. Let's look at the first exhibit, which is your CV.

A. Yes.

Q. You don't practice medicine as a pharmacist, do you?

A. No.

Q. And if you could, I don't need you to go into detail because the Court has your CV in front of you, but can you just give a brief 30-second description of your experience.

A. As I said, I'm a pharmacist by education. I've tended to specialize over the years in an area that is called "drug information." This is the retrieval and the critical analysis [335] of the published literature. I have a lot of experience—substantial experience in academia as a tenured faculty member at Idaho State University College of Pharmacy. And at that institution I was also the acting associate dean. More recently, I was the department chair at the LECOM School of Pharmacy in Erie, Pennsylvania, until 2010.

Q. Okay. And I'm going to just briefly have you look at each of the other two or three exhibits that are attached to your CV. The next one is Exhibit 2. And what is this?

A. This is the USFDA-approved professional product information, sometimes called the "package insert," for midazolam injection.

Q. Okay. And let's take a quick look at Exhibit 3.

A. This is an FDA-approved package insert or professional product label for the drug vecuronium.

Q. And let's take a quick look at Exhibit 4. Could you please identify that.

A. This is a professional product label or package insert for potassium chloride injection.

Q. And did you rely upon those drug labels in reaching your opinions in your report?

A. Yes, I did.

Q. And why do you rely on the drug labels here?

A. These are—professional product labels are the most objective and complete information that we have about a drug [336] and its legal use within the United States. Professional product labels are actually legal documents. So we know in a professional practice—professional product label that scientific studies have been submitted and reviewed by the FDA before any information can actually go into a professional product label.

Q. Would you rely on a source such as drugs.com?

A. No, I wouldn't. And I would probably not accept a work product from a student that provided me a report where drugs.com was used as the reference source.

Q. And why is that that you wouldn't rely on a source such as drugs.com?

A. Well, the sources that drug.com (sic) uses are a number of other sources, for instance, Micromedex, Epocrates, Lexi-Comp. Those publications or those products have been criticized in the peer-reviewed medical literature for poor editorial policies, including being out of date and incomplete.

Q. And I'd like to turn your attention to what's marked as Plaintiffs' Exhibit 88. This is an article called "Box Warning Inconsistencies between Drug Information Resources and the Prescribing Information." Are you familiar with this article?

A. Yes, I am.

Q. And if we could take a look at page 3 and if you could explain to me what exactly this article is, Dr. Sasich.

A. Well, this—in this article, the researchers surveyed

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[342] opinions that you've expressed in your report?

A. No, they did not.

Q. Let's talk about your report. In Section 1, you talk about midazolam.

A. Correct.

Q. And in—you state that there are three reasons that it is inappropriate, in your opinion, to select this drug as an anesthetic drug in Oklahoma's execution procedure.

A. Yes.

Q. Do you see that last sentence under Section 1?

A. Yes.

Q. And what are the three reasons?

A. It has no analgesic effect, it has a ceiling effect, and it can cause a paradoxical reaction.

Q. Okay. Let's start with your first opinion, that it has no analgesic effect. Is there any argument that it

does relieve pain? Is there any evidence to show that it does have an analgesic effect?

A. I'm not aware of any credible scientific argument that it does and it's—actually, it's not approved by the FDA to use in such a way that it would alleviate or prevent pain.

Q. And your opinion also states at the top of page 4 that studies have shown midazolam increases the perception of pain.

A. Yes. We do have—we do have one randomized controlled trial that for different types of pain stimuli that there was a

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[345] THE WITNESS: A-N-I-X-O-L-Y-T-I-C (sic). That means it reduces anxiety.

THE COURT: Okay. Go ahead.

Q. (BY MS. KONRAD) And you mentioned the FDA, so let's turn to the FDA label for midazolam. In particular, I'm looking at your Exhibit 2 and it's six pages into that exhibit, which that label says "Indications and Usage."

A. Uh-huh.

Q. What does that mean?

A. That means that the manufacturer, the sponsor of the drug, has submitted clinical trials that have been reviewed by FDA scientists, qualified researchers, qualified statisticians, that show that the drug actually does what the manufacturer says that it will do. And those are the only uses that a manufacturer can place in a professional product label for a drug, only those uses that have been—that are supported by high-quality scientific research that have

been reviewed and approved by the United States Food and Drug Administration, period.

Q. And is one of the uses of midazolam to be for the administration of anesthesia for purposes of surgery?

A. No.

Q. And so what does that mean?

A. That you wouldn't use it as a single agent to try and perform any kind of surgical procedure.

[346] Q. But does that mean that it was tested and failed or that it wasn't tested for that purpose or do we know?

A. Well, both are possible. It's possible that the manufacturer of the drug did not seek approval for that indication or the manufacturer of the drug submitted data that was insufficient and so the drug failed for that use and it doesn't wind up on the professional product label.

Q. And do you have—you heard Dr. Lubarsky's testimony yesterday where he was speaking about the ceiling effect of midazolam.

A. Uh-huh.

Q. Do you have any disagreement with his description of the ceiling effect for midazolam?

A. No. I thought he did a good job of communicating what sometimes is a difficult pharmacological principle to the general public.

MS. KONRAD: Now would be a good time to take a break and I'll finish up after lunch.

THE COURT: Very well. We'll take our midday break at this time. We'll resume at five minutes after

one, again, guided by the clock on the wall. Court will be in recess.

(RECESS HAD.)

THE COURT: Counsel, you may continue.

Q. (BY MS. KONRAD) Dr. Sasich, before lunch, we were talking about your report and I'd like to turn your attention to [347] Section C of your report under midazolam where we're talking about paradoxical reaction.

MS. KONRAD: While she's doing that, may I approach the witness?

THE COURT: Surely. I've got a copy of it right here and so I can certainly follow along.

MS. KONRAD: I'm okay to proceed without it.

THE COURT: Please do.

Q. (BY MS. KONRAD) Dr. Sasich, if you look at Section C of your report—

A. Yes.

Q. —that says paradoxical reaction. Can you explain what a paradoxical reaction is?

A. Well, with a drug like midazolam or other drugs in its class, the benzodiazepines, you expect somebody to become sedated, become less anxious, become sleepy. But what happens in a paradoxical reaction is the opposite happens. They become agitated, they may be combative, and they can become very, very combative.

Q. Okay. And you—where do you get this information from that midazolam has a paradoxical reaction or could have a paradoxical reaction?

A. Well, the clearest indication is from the drug's professional product label. And the first portion under C of my report is taken directly from the professional product label

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[350] good source.

Q. Okay. And speaking of this paradoxical reaction, if there is a paradoxical reaction that somebody has to midazolam, can it happen once the person has been sedated by the midazolam?

A. Yes. We have—and I cited a case report in which somebody had been sedated and then received a surgical manipulation and was aroused or awakened or—then the paradoxical reaction started.

Q. And is there—you cite in your report saying that literature notes that certain populations might be more at risk, such as individuals who have a history of aggressive or impulsive behaviors, a history of drug or alcohol abuse, or a history of psychiatric disorders. Where does that information come from?

A. That comes from some of the people that have looked at or studied paradoxical reactions. And so we see—the polite statistical term we use is one that's called an "association," that there seems to be a relationship between personalities and the—and a paradoxical reaction. This is—doesn't show a true cause-and-effect relationship. But rarely do we do the types of reactions that would allow us to state unequivocally that this drug caused this reaction because this person had a particular personality or type of personality. You simply—you can't do it. You don't do trials to try and induce harm. And that's one of the reasons that this concept of risk of

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[358] A. It's not approved for that use, correct.

Q. And, again, in your opinion here, the reasons why are, you know, why isn't midazolam used for this purpose?

A. Either the manufacturer did studies to try and show that it was effective for this purpose and the drug failed in those clinical trials or the manufacturer never attempted to market the drug as an anesthetic for use in surgery and simply didn't present any data.

Q. Okay. And looking at your conclusion here you said because of the chemical properties, including having no analgesic effect and having a ceiling effect—are those both facts that we know about midazolam?

A. Yes, we do.

Q. Is there evidence to contest the fact that midazolam has no analgesic effect and that it, in fact, has a ceiling effect, is there any data to contest that—those two facts are true?

A. Well, certainly not on the point about being an anesthetic. I was a little surprised about the arguments on the ceiling effect because the literature that I reviewed said, as a class, the benzodiazepines exhibit a ceiling effect and this ceiling effect would be something that you would see with almost every drug as it's going through the drug approval process, the basic pharmacology of the drug looking at the dose response.

Q. And you also said that because midazolam produces a

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[367] Q. Oh, do you have it there in front of you? Let's just go to page 3, then.

A. Page 3?

Q. Yes, sir. If you have that.

A. Yes. I'm at page 3.

Q. All right. I just wanted to start there. At the bottom there I had noted you had been asked some questions about analgesic effect. Do you recall that?

A. Yes, I do.

Q. So your testimony is that there's no analgesic effect whatsoever to midazolam, correct?

A. Correct.

Q. You would agree with me, though, that if someone was unconscious, that whether there's an analgesic effect or not is of no consequence, correct?

A. No.

Q. And why do you say that?

A. Because they could be aroused by painful stimuli and no longer be unconscious.

Q. But if they're unconscious to the point that they could resist the noxious stimuli, the fact that there is no analgesic effect would be of no consequence, correct?

A. But I don't know what that point is. So, you know, I can't—I can't answer that question, so—it would be pure speculation on my part.

[368] Q. Okay. Doctor, do you have some knowledge of the general uses of midazolam in common practice?

A. Yes, I do.

Q. Is it your testimony that there are no licensed practitioners in the United States of America utilizing midazolam without an analgesic for any procedure?

A. Oh, yeah, certainly. Many procedures that don't require anesthesia.

Q. Okay. So you're saying there are people using midazolam but not an analgesic?

A. Right. Not as anesthesia.

Q. Okay.

A. And where it's a very useful drug.

Q. Okay. What types of procedures would you use it with and not utilize an analgesic?

A. For—you might do it in a colonoscopy, a gastroscopy.

Q. I'm sorry. Slow down just one moment, please.

A. Oh, I'm sorry.

Q. I imagine the court reporter may need you to spell a couple of those. What was the second one you said?

A. Oh, putting a tube down the stomach to view it.

Q. Okay. I've got it.

A. Putting a tube or a camera in the gastrointestinal tract to view it. Minor procedures that may involve insertion of a catheter, the examination of the urinary output channel in both [369] males and females, the urethra, the tube that goes from the kidneys through which we urinate.

Q. Okay. So sounds like here we're talking about insertion of some sort of medical device in some place

in a human that are—I would assume there's some noxious stimuli associated with that, is there not?

A. Well, there certainly may be. But I think, at least in my experience, the people that are facing a colonoscopy, you know, examination of the gastrointestinal tract looking for polyps that are potentially precancerous, this is a major screening program in the United States, one of the things that prevents a lot of people from undergoing this screening is their anxiety over the idea of somebody inserting some type of device in their rectum.

Q. Right. Now, on a colonoscopy, Doctor, they don't just put a camera up there, do they? Don't they also sometimes excise and cut out polyps?

A. Yes, uh-huh.

Q. So it's your testimony that you could receive a tube inserted into you that goes up into you and they cut a piece out of you, but that is less noxious than receiving an injection of vecuronium bromide or potassium chloride. Is that what you're saying?

A. You took a big jump from midazolam to vecuronium and potassium chloride. You're clipping out a polyp—

[370] Q. Right.

A. —one or more—

Q. Noxious stimuli—

THE COURT: Don't interrupt. Let him answer. Go ahead.

THE WITNESS: As far as I'm aware, that—that's not painful.

Q. (BY MR. HADDEN) Okay. And you don't think its painful to receive a tube down your throat to examine your gastrointestinal tract?

A. Well, I would say it would be uncomfortable and it makes somebody extremely anxious with the idea. I mean, just thinking about it, I think, would make most people nervous or anxious.

Q. And the same for having a tube inserted up your urethra?

A. Yes.

Q. So absent someone's trepidation about having that happen, it's your testimony that that is not a painful procedure?

A. As far as, to the best of my knowledge, that many of these procedures are conducted without the need for additional analgesic on an outpatient basis so people can go home and they aren't trying to drive or go home having an opiate, for example.

Q. Okay. Okay. So if we would turn, then, on your report to page 4.

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[378] another part of Korea, they're likely to get a different number—

Q. Okay.

A. —just because of the variation that there is in individuals. We're not like little machines when we're—you know, we—well, I'm sure you're aware of that, that we all react to drugs in different ways.

Q. Yes, sir. So as you sit here today, though, Doctor, you cannot say whether the Oklahoma inmate

population would be at the 1 percent or lower range or up to the 15 percent range, correct?

A. Correct.

Q. Moving on, Doctor, if you would turn to page 6, please.

A. Okay.

Q. I wanted to look just briefly at that paragraph, the numbered parts, that starts, "The drug is approved for IV use."

A. Okay.

Q. Do you see that, Doctor?

A. "The drug is approved for IV use only for surgical procedures and mechanical ventilation or breathing. These procedures are performed in hospitals under close monitoring. Examples of vecuronium bromide infiltration could not be found in the literature."

Q. Let's stop right there, Doctor. The part where the second line—where you say, "These procedures are performed in

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[383] very last paragraph, in the middle of it, you said, "Mr. Lockett would have experienced severe pain from the infiltrated potassium chloride." Do you recall that?

A. Yes.

Q. Do you think you're qualified with your education and experience to testify about such a thing?

A. Sure, absolutely. Spent a lot of time in hospitals.

Q. Do you personally have knowledge of the noxious effect of potassium chloride, Doctor?

A. No, I've never received it, but my wife has and she said it was the worst burning sensation she ever had in her whole life.

Q. Okay. But have you seen patients, other than your wife, injected with it or subjected to it at some point?

A. Oh, yeah, and saying the—and saying the same thing, that it was extremely painful. I've discussed with nurses that we have to turn the rate of administration down or stop it for a while. You run the risk of really inflaming a vein. And, you know, I know this is not your concern, but for a patient that you want to leave the hospital, somebody that has an inflamed vein, they can lose it, so you want to be very careful.

Q. Okay. In your opinion, then, Doctor, and I know you don't have—you just said you have never been personally injected with it, but, in your opinion, do you think the noxious effect

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[389] midazolam that the average person would not be rendered unconscious?

A. Not be rendered—I really don't know what the reaction would be. That dose is so much higher than we have any evidence or description of. You could run into a whole other set of adverse reactions that we hadn't seen before.

Q. As you sit here today, though, Doctor, can you say to a reasonable degree of medical certainty IV infusion of 500 milligrams of midazolam will not render someone unconscious? Can you say that?

A. Oh, no, but neither can anyone else.

Q. Okay. One last thing, Doctor. You had been asked some questions about Defendants' 34, which was Bates stamp 6556, that MSDS.

A. Yes.

Q. Okay. I just wanted to ask you just one or two brief questions about that. But the MSDS is something that is required to be prepared by the United States Government, is it not?

A. No, by the manufacturer or by the—I believe it's under OSHA standards and OSHA sets the regulations as what has to be in the Material Safety Data Sheet. And I believe it's the manufacturers that write them.

THE COURT: You've answered the question. Next question.

* * * *

[REDIRECT]

[392] into the weeds.

Q. And if somebody asked you whether a drug would be safe and effective for a certain purpose, what information would you recommend that person review?

A. Well, certainly, even if it is a prescription drug, I would recommend the professional product label, that they read that on the National Library of Medicine's Web site because there's parts of professional product labels that are written specifically for patients and there are also parts of the labels for some drugs that have quite extensive risk information that is written specifically for patients

that must be distributed by pharmacists for each new and refill prescription.

Q. And just two more questions. Mr. Hadden asked you about some executions that happened in Florida. And in Florida, they use a 500 milligram dose of midazolam followed by a paralytic and then potassium chloride, which is similar to what Oklahoma is proposing to do in their upcoming executions. If an individual was, in fact, rendered unconscious by midazolam and was then given a paralytic, would that person then be able to express pain through movement?

A. No, they wouldn't be able to speak or move.

Q. Okay. And final question: Do you know of any data to support that midazolam is a drug that can sufficiently and reliably render someone unconscious such that noxious stimuli

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

CHARLES F. WARNER, ET AL

vs.

KEVIN J. GROSS, ET AL.,

NO. CIV-14-665-F

REVIEW OF THE EXPERT REPORT AND ORAL TESTIMONY OF R. LEE EVANS

Prepared by
Larry D. Sasich, PharmD, MPH, FASHP
Burlington, ON, Canada

January 8, 2015

This document reviews the oral testimony and report of R. Lee Evans, Pharm.D., provided for a hearing held in Oklahoma City, OK December 17 – 19, 2014 in the matter of Warner, et al vs. Gross, et al. Particular attention is placed on the quality, soundness and completeness of the report and the oral testimony.

EVANS' REPORT

The report consisted of 365 pages, 5 of which were an original written submission. The first part of this document is a review of the references cited as

purportedly supporting Evans' conclusions. The following is the list of references cited by Evans in support of the report.

- www.Drugs.Com (for health professionals) for Thiopental, Pentobarbital, Hydromorphone, Potassium Chloride, Midazolam, Vecuronium Bromide, Pancuronium Bromide or Rocuronium Bromide
- Material Safety Data Sheet for Midazolam Injection, Bedford Laboratories, 2007.
- Clinical Practice Guidelines for Sustained Neuromuscular Blockade in the Adult Critically Ill Patient.
- ASHP Therapeutic Guidelines. American Society of Health System Pharmacists, 2001.
- Final Report on the Safety Assessment of Benzyl Alcohol, Benzoic Acid, and Sodium Benzoate. International Journal of Toxicology 2001:20; 23.
- Benzyl Alcohol. PubChem.ncbi.nlm.gov/compound/benzyl alcohol.

Drugs.Com

This Web site is owned and operated by the Drugsite Trust, a privately held Trust administered by two New Zealand pharmacists. Their Mission Statement is:

> "to empower patients with the knowledge to better manage their own healthcare and to improve consumer safety by assisting in the reduction of medication errors."

The following disclaimer appears on the Drugs.com Web site:

"This material is provided for educational purposes only and is not intended for medical advice, diagnosis or treatment."

The Drugs.com drug database uses material from four medical-information vendors: Wolters Kluwer Health [Facts and Comparisons], American Society of Health-System Pharmacists, Cerner Multum and Thomson Reuters Micromedex [DrugDex]. Individual drug (or drug-class) information content compiled by these sources is delivered complete and unaltered by Drugs.com.

The editorial policies of the reference sources that are used unaltered by Drugs.com have been found to be out of date, incomplete, and of general low editorial quality since the early 1970s.[1] [2] [3] [4]

A major source for the drug information available on the Drugs.com site is the American Hospital Formulary Service Drug Information Essentials (AHFS DI Essentials), a product of the American Society of Health-System Pharmacists. AHFS DI Essentials is promoted as "a resource that focuses on

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[1] Department of Health and Human Services Food and Drug Administration. Prescription Drug Product Labeling; Medication Guide Requirements. Federal Register 1995:44182-44252.

[2] Abernethy AP, Raman G, Balk EM, et al. Systematic review: reliability of compendia methods for off-label oncology indications. Ann Intern Med. Mar 3 2009;150(5):336-343.

[3] Cheng CM, Fu C, Guglielmo BJ, Auerbach AD. Boxed warning inconsistencies between drug information resources and the prescribing information. American journal of health-system pharmacy : Am J Health Syst Pharm. Sep 1 2011;68(17):1626-1631

[4] Paczynski RP, Kruszewski SP. Inadequacies of Statutory Drug Compendia Also Affect the Mental Health Field. Ann Intern Med. September 1, 2009 2009;151(5):364-365.

the essential evidence-based information that will allow pharmacists, nurses, physicians, and other health-care providers quickly access the specific guidance needed to safely and effectively monitor and prescribe drug therapy."

However, the term "evidence based" is now greatly overused and has lost much of its original intended meaning. The original meaning of the term was for medical treatment recommendations based on the best available evidence that is up to date and of high quality. This included well-done controlled clinical trials as being the most authoritative with clinical opinion, uncontrolled clinical observations, being the lowest quality of evidence. Commercial medical information vendors routinely attach "evidence based" to their products without definition.

Drug Information Sources

The table below examines the drug information sources cited in the Evans report. The information cited by Evans was downloaded from the Drugs.com Web site and uses information from the American Hospital Formulary Service Drug Information Essentials (AHFS DI Essentials) a product from the American Society of Health-System Pharmacists.

The term "selected revisions" is not defined by AHFS DI Essentials. There is no indication that these selected revisions ensure that this information is derived from or consistent with the essential information that is contained in the most current professional product labels for these drugs.

It is difficult to rationalize why Evans did not use the most current FDA approved professional product labels as the bases for his report. This information is available free to the public on the government's

DailyMed Web site. This reflects negatively on the quality of the information used in his report and that apparently also formed the bases of his testimony.

Drug/Original Source of Information	Comments
Pentobarbital AHFS DI Essentials. Selected Revisions February 1, 2008. American Society of Health-System Pharmacists, Inc	The Drugs.com information is at least 6 years out of date. The current FDA approved professional product label from Akorn, Inc., last revised 4/12. Link to current pentobarbital professional product label: http://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=5c380eb0-4388-48b8-80ab-ce584b23bc74
Hydromorphone AHFS DI Essentials. Selected Revisions July 9, 2013. American Society of Health-System Pharmacists, Inc.	The Drugs.com information omits the FDA required box warning for hydromorphone. The current FDA approved professional product label from Akorn, Inc., last revised 2/13. Link to current hydromorphone professional product label: http://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=4d33b072-0755-4b6c-9558-2551306756e3
Thiopental AHFS DI Essentials. Copyright, 2004-2014, Selected Revisions July 1, 2007. American Society of Health-System Pharmacists, Inc.	This product is no longer marketed in the US.

Drug/Original Source of Information	Comments
Midazolam AHFS DI Essentials. Copyright, 2004-2014, Selected Revisions July 10, 2013. American Society of Health-System Pharmacists, Inc.	The Drugs.com information omits the FDA required box warning of midazolam. The current FDA approved professional product label from Akorn, Inc., last revised 7/12. Link to current FDA approved professional product label for midazolam: http://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=737361e0-8d1d-4d3c-be5e-44df3f49fe22

Other Documents Submitted

The table below reviews the other references provided in the Evans report.

Document/Source	Comments
PubChem Database Final Report on the Safety Assessment of Benzyl Alcohol, Benzoic Acid, and Sodium Benzoate International Journal of Toxicology 2001; 20: 23.	This 13 year old document concludes: "...Benzyl Alcohol, Benzoic Acid, and Sodium Benzoate are safe for use in cosmetic formulations at concentrations up to 5%. The available data are insufficient to support the safety of these ingredients in cosmetic products in which a primary route of exposure is inhalation. Benzyl Alcohol is safe for use in hair dyes at concentrations up to 10%."
Bedford Laboratories Midazolam Material Safety Data Sheet	This document was last revised July 17, 2007 and is not an FDA requirement. In the U.S., the Occupational Safety and Health Administration requires that MSDSs be available to employees for potentially harmful substances handled in the workplace under the Hazard Communication regulation. The disclaimer on this document contains the following language: "It is not a specification sheet and none of the displayed data should be construed as a specification. Information on this MSDS sheet was obtained from sources, which we believe are reliable, and we believe that the information is complete and accurate. However, the information is provided without any warranty, express or implied, regarding its correctness."

Document/Source	Comments
ASHP Therapeutic Guidelines Clinical Practice Guidelines for Sustained Neuromuscular Blockade in the Adult Critically Ill Patient Society of Critical Care Medicine and American Society of Health-System Pharmacists. Clinical practice guidelines for sustained neuromuscular blockade in the adult critically ill patient. Am J Health Syst Pharm. 2002; 59:179–95.	This document is 12 years old. The methodology for the preparation of this clinical practice guideline was not provided making it impossible to access its quality. Nevertheless, the following is of relevance in the Warner vs. Gross case: "Even though the patient may appear quiet and "comfortable," experienced clinicians understand the indications and therapeutic limits of NMBAs [neuromuscular blocking agents]. Despite multiple admonitions that NMBAs have no analgesic or amnestic effects, it is not uncommon to find a patient's degree of sedation or comfort significantly overestimated or even ignored. It is difficult to assess pain and sedation in the patient receiving NMBAs, but patients must be medicated for pain and anxiety, despite the lack of obvious symptoms or signs. In common practice, sedative and analgesic drugs are adjusted until the patient does not appear to be conscious and then NMBAs are administered. There have been no studies of the use of electrophysiologic monitoring in assessing adequacy of sedation or analgesia."

ORAL TESTIMONY

The table below reviews Evans' oral testimony.

Testimony – Page and Line Numbers	Analyses
Page 632, Lines 4 – 6 Evans states "I mean, even for something like a colonoscopy, you would see it used in combination with a narcotic."	The removal of polyps causes no pain Dartmouth-Hitchcock. Colon Polypectomy (Polyp Removal) http://www.dartmouth-hitchcock.org/gi/colon_polypectomy.html. Accessed 12/29/14

Page 633 Lines 20 and 21 Evans claims "There have been at least 80 case reports of fatalities in the country from midazolam, the use of midazolam."	Although Evans provides no citation, his statement may be from the PubChem database maintained by the US National Center for Biotechnology Information for midazolam. This document says "often in combination with opioids." The citation used by PubChem is Bailly PL et al; Anesthesiology 73 (5): 826-30 (1990). This PubChem document was not on Evans' list of references. Evans' statement is incomplete because he omitted that the data indicates that midazolam was used in combination with an opioid drug, and because he relied on a source that is at least 25 years out of date.
Page 636 Lines 13 – 19 Evans discussion of ceiling effect	Evans' discussion is difficult to follow. No reference is provided to support his opinion about a lack of a ceiling effect with midazolam. The term ceiling effect is defined as "the phenomenon in which a drug reaches a maximum effect, so that increasing the drug dosage does not increase its effectiveness."
Page 636 Lines 20 – 23 Evans is referring to the reticular activating system as the respiration center.	Evans' statement is incorrect. The reticular activating system (RAS), or extra-thalamic control modulatory system, is a set of connected nuclei in the brains of vertebrates that is responsible for regulating arousal and sleep-wake transitions.
Page 637 Line 11 to Page 638 Line 2 Discussion of GABA receptors	Evans' response is unclear. GABA is the main inhibitory neurotransmitter in the central nervous system. Midazolam increases the effects of GABA, an effect that results in its pharmacologic effects.
Page 640 Lines 3 – 5 Response on feeling pain with midazolam	There are examples of patients sedated with midazolam that have responded to painful stimuli [1] 1. Rodrigo CR. Flumazenil Reverses Paradoxical Reaction with Midazolam. Anesth Prog. 1991; 38:65-68.
Page 640 Line 18 to Page 641 Line 11 Discussion of midazolam's paradoxical reaction	There are estimates of the prevalence of the paradoxical reaction that range from 1% to 10% that come from studies counting sequential paradoxical reactions in specific populations. A 1% prevalence of an adverse drug reaction is not small and will mean that a large number of people will experience that reaction.

Page 645 Line 20 to Page 646 Line 22 Discussion of involuntary movements and the Saponsik study	Saponsik studied 107 brain dead patients. There are several sets of criteria for the diagnosis of brain death, all require complete unresponsiveness, permanent loss of breathing and absent brainstem reflexes; most also require the absence of sedative drugs, neuromuscular blocking agents, and low body temperature. The majority of subjects did not have spontaneous movements. Brain death is not verified in executed prisoners.
Page 647 Lines 15 – 17 Discussion of pain with midazolam injections	Midazolam's FDA-approved professional product label indicates that 5% of patients experience pain on injection.
Page 650 Line 1 to Page 651 Line 23 Discussion of ceiling effect with midazolam	Evans is confused about these studies and corrects himself. He offered no credible evidence that there is no ceiling effect with midazolam.
Page 651 Lines 24-25 & Page 652 Lines 1 – 10 Discussion of Drugs.com	Evans refers to Drugs.com as a tertiary source. This is a term that is usually used for textbooks. A more appropriate term would be information aggregator. Drugs.com uses information from commercial drug information vendors. The Drugs.com disclaimer contains the following statement: "This material is provided for educational purposes only and is not intended for medical advice, diagnosis or treatment." Sources in Drugs.com have been criticized in the literature for poor editorial policies.

CONCLUSION

My critique of Evans' report is based on over 30 years of experience teaching drug information, also referred to as clinical epidemiology, to pharmacy students in accredited colleges of pharmacy in North America and to pharmacists and other health professionals overseas. This instruction included the retrieval, critical evaluation, and objective communication of the best available evidence about drugs.

Evans' report relied mainly on the Drugs.com Web site as its major source for drug information. Drugs.com is an information aggregator that relies on

unaltered information from a number of popular commercial drug information vendors that have been criticized in the published literature, extending back to the 1970s, because of poor editorial policies resulting in information that can be incomplete and out of date or both.

The other references provided in Evans' report were a document from PubChem, a chemical information database, from the US National Center for Biotechnology Information for midazolam. Also submitted was a Material Safety Data Sheet (MSDS) for midazolam prepared by Bedford Laboratories that was last revised in July 2007. MSDSs are a requirement of the Occupational Health and Safety Administration for employers to prepare and make available in the workplace. Finally, he relied on a 12-year-old clinical practice guideline from the American Society of Health-System Pharmacists on sustained neuromuscular blockade in the adult critically ill patient.

Absent from Evans' report was information on midazolam's paradoxical reaction, with the exception of a document from Drugs.com that was not reflected in his written submission. Also absent from his report was any mention of evidence to refute a ceiling effect that has been cited in the published literature with midazolam.

Any extrapolation based on the information submitted that 500 mg of midazolam would render an individual unconscious and insensate to noxious stimuli is at best only speculative.

Errors in Evans' oral testimony are documented above. Taken together, the report and the oral testimony reveal a lack of scientific thoroughness and

accuracy that places in question his opinions and conclusions.

/s/ Larry D. Sasich	1/8/15
Larry D. Sasich	Date

MIDAZOLAM- midazolam hydrochloride injection
Akorn, Inc.

Midazolam Injection, USP
Rx only
CIV

WARNING

Adult and Pediatric: Intravenous midazolam has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings. In some cases, where this was not recognized promptly and treated effectively, death or hypoxic encephalopathy has resulted. Intravenous midazolam should be used only in hospital or ambulatory care settings, including physicians' and dental offices, that provide for continuous monitoring of respiratory and cardiac function, i.e., pulse oximetry. Immediate availability of resuscitative drugs and age- and size-appropriate equipment for bag/valve/mask ventilation and intubation, and personnel trained in their use and skilled in airway management should be assured. (see WARNINGS.) For deeply sedated pediatric patients, a dedicated individual, other than the practitioner performing the procedure, should monitor the patient throughout the procedure.

The initial intravenous dose for sedation in adult patients may be as little as 1 mg, but should not exceed 2.5 mg in a normal healthy adult. Lower doses are necessary for older (over 60 years) or debilitated patients and in patients receiving concomitant narcotics or other central nervous system (CNS)

depressants. The initial dose and all subsequent doses should always be titrated slowly; administer over at least 2 minutes and allow an additional 2 or more minutes to fully evaluate the sedative effect. The use of the 1 mg/mL formulation or dilution of the 1 mg/mL or 5 mg/mL formulation is recommended to facilitate slower injection. Doses of sedative medications in pediatric patients must be calculated on a mg/kg basis, and initial doses and all subsequent doses should always be titrated slowly. The initial pediatric dose of midazolam for sedation/anxiolysis/amnesia is age, procedure, and route dependent (see DOSAGE AND ADMINISTRATION for complete dosing information).

Neonates: Midazolam should not be administered by rapid injection in the neonatal population. Severe hypotension and seizures have been reported following rapid IV administration, particularly with concomitant use of fentanyl (see DOSAGE AND ADMINISTRATION for complete information).

DESCRIPTION

Midazolam hydrochloride is a water-soluble benzodiazepine available as a sterile, nonpyrogenic parenteral dosage form for intravenous or intramuscular injection. Each mL contains midazolam hydrochloride equivalent to 1 mg or 5 mg midazolam compounded with 0.8% sodium chloride and 0.01% disodium edetate, with 1% benzyl alcohol as preservative; the pH is adjusted to 3.3 to 3.5 with hydrochloric acid and, if necessary, sodium hydroxide.

Midazolam is a white to light yellow crystalline compound, insoluble in water. The hydrochloride salt of midazolam, which is formed *in situ*, is soluble in aqueous solutions. Chemically, midazolam HCl is 8-chloro-6-(2-fluoro-phenyl)-1-methyl-4H-imidazo[1,5-

a][1,4]benzodiazepine hydrochloride. Midazolam hydrochloride has the molecular formula $C_{18}H_{13}ClFN_3 \cdot HCl$, a calculated molecular weight of 362.25 and the following structural formula:

* * * *

increase in the clearance and volume of distribution but the half-life remained unchanged. Metabolite levels were not studied.

Plasma Concentration Effect Relationship: Concentration-effect relationships (after an IV dose) have been demonstrated for a variety of pharmacodynamic measures (e.g., reaction time, eye movement, sedation) and are associated with extensive intersubject variability. Logistic regression analysis of sedation scores and steady-state plasma concentration indicated that at plasma concentrations greater than 100 ng/mL there was at least a 50% probability that patients would be sedated, but respond to verbal commands (sedation score = 3). At 200 ng/mL there was at least a 50% probability that patients would be asleep, but respond to glabellar tap (sedation score = 4).

Drug Interactions: For information concerning pharmacokinetic drug interactions with midazolam, see PRECAUTIONS.

INDICATIONS AND USAGE:

Midazolam injection is indicated:

- intramuscularly or intravenously for preoperative sedation/anxiolysis/amnesia;
- intravenously as an agent for sedation/anxiolysis/amnesia prior to or during diagnostic, therapeutic or endoscopic procedures, such as bronchoscopy, gastroscopy, cystoscopy, coronary

angiography, cardiac catheterization, oncology procedures, radiologic procedures, suture of lacerations and other procedures either alone or in combination with other CNS depressants;

- intravenously for induction of general anesthesia, before administration of other anesthetic agents. With the use of narcotic premedication, induction of anesthesia can be attained within a relatively narrow dose range and in a short period of time. Intravenous midazolam can also be used as a component of intravenous supplementation of nitrous oxide and oxygen (balanced anesthesia);
- continuous intravenous infusion for sedation of intubated and mechanically ventilated patients as a component of anesthesia or during treatment in a critical care setting.

Midazolam is associated with a high incidence of partial or complete impairment of recall for the next several hours (see CLINICAL PHARMACOLOGY).

CONTRAINDICATIONS:

Injectable midazolam is contraindicated in patients with a known hypersensitivity to the drug. Benzodiazepines are contraindicated in patients with acute narrow-angle glaucoma. Benzodiazepines may be used in patients with open-angle glaucoma only if they are receiving appropriate therapy. Measurements of intraocular pressure in patients without eye disease show a moderate lowering following induction with midazolam; patients with glaucoma have not been studied.

Midazolam is not intended for intrathecal or epidural administration due to the presence of the preservative benzyl alcohol in the dosage form.

WARNINGS:

Midazolam must never be used without individualization of dosage particularly when used with other medications capable of producing central nervous system depression. Prior to the intravenous administration of midazolam in any dose, the immediate availability of oxygen, resuscitative drugs, age-and size-appropriate equipment for bag/valve/mask ventilation and intubation, and skilled personnel for the maintenance of a patent airway and support of ventilation should be ensured. Patients should be continuously monitored with some means of detection for early signs of hypoventilation, airway obstruction, or apnea, i.e., pulse oximetry. Hypoventilation, airway obstruction, and apnea can lead to hypoxia and/or cardiac arrest unless effective countermeasures are taken immediately. The immediate availability of specific reversal agents (flumazenil) is highly recommended. Vital signs should continue to be monitored during the recovery period. Because intravenous midazolam depresses respiration (see CLINICAL PHARMACOLOGY) and because opioid agonists and other sedatives can add to this depression, midazolam should be administered as an induction agent only by a person trained in general anesthesia and should be used for sedation/anxiolysis/amnesia only in the presence of personnel skilled in early detection of hypoventilation, maintaining a patent airway and supporting ventilation. When used for sedation/anxiolysis /amnesia, midazolam should always be titrated slowly in adult or pediatric patients. Adverse hemodynamic events have been reported in pediatric patients with cardiovascular instability; rapid intravenous administration should also be avoided in this

population. See DOSAGE AND ADMINISTRATION for complete information.

Serious cardiorespiratory adverse events have occurred after administration of midazolam. These have included respiratory depression, airway obstruction, oxygen desaturation, apnea, respiratory arrest and/or cardiac arrest, sometimes resulting in death or permanent neurologic injury. There have also been rare reports of hypotensive episodes requiring treatment during or after diagnostic or surgical manipulations particularly in adult or pediatric patients with hemodynamic instability. Hypotension occurred more frequently in the sedation studies in patients premedicated with a narcotic.

Reactions such as agitation, involuntary movements (including tonic/clonic movements and muscle tremor), hyperactivity and combativeness have been reported in both adult and pediatric patients. These reactions may be due to inadequate or excessive dosing or improper administration of midazolam; however, consideration should be given to the possibility of cerebral hypoxia or true paradoxical reactions. Should such reactions occur, the response to each dose of midazolam and all other drugs, including local anesthetics, should be evaluated before proceeding. Reversal of such responses with flumazenil has been reported in pediatric patients. Concomitant use of barbiturates, alcohol or other central nervous system depressants may increase the risk of hypoventilation, airway obstruction, desaturation, or apnea and may contribute to profound and/or prolonged drug effect. Narcotic premedication also depresses the ventilatory response to carbon dioxide stimulation.

Higher risk adult and pediatric surgical patients, elderly patients and debilitated adult and pediatric

patients require lower dosages, whether or not concomitant sedating medications have been administered. Adult or pediatric patients with COPD are unusually sensitive to the respiratory depressant effect of midazolam. Pediatric and adult patients undergoing procedures involving the upper airway such as upper endoscopy or dental care, are particularly vulnerable to episodes of desaturation and hypoventilation due to partial airway obstruction. Adult and pediatric patients with chronic renal failure and patients with congestive heart failure eliminate midazolam more slowly (see CLINICAL PHARMACOLOGY). Because elderly patients frequently have inefficient function of one or more organ systems and because dosage requirements have been shown to decrease with age, reduced initial dosage of midazolam is recommended, and the possibility of profound and/or prolonged effect should be considered.

Injectable midazolam should not be administered to adult or pediatric patients in shock or coma, or in acute alcohol intoxication with depression of vital signs. Particular care should be exercised in the use of intravenous midazolam in adult or pediatric patients with uncompensated acute illnesses, such as severe fluid or electrolyte disturbances.

There have been limited reports of intra-arterial injection of midazolam. Adverse events have included local reactions, as well as isolated reports of seizure activity in which no clear causal relationship was established. Precautions against unintended intra-arterial injection should be taken. Extravasation should also be avoided.

The safety and efficacy of midazolam following nonintravenous and nonintramuscular routes of admin-

istration have not been established. Midazolam should only be administered intramuscularly or intravenously.

The decision as to when patients who have received injectable midazolam, particularly on an outpatient basis, may again engage in activities requiring complete mental alertness, operate hazardous machinery

December 2, 2014

Mr. John D. Hadden
Assistant Attorney General
Litigation Division Office of the Attorney General
313 North East 21st Street
Oklahoma City, OK 73105

Re: Charles F. Warner, et al, v. Gross, et al,
No CIV-14-665F

Dear Mr. Hadden:

I have been requested to address the pharmacological effects of the drugs used in the execution protocol for the State of Oklahoma. The following outlines the classification of the drugs in the protocol, their mechanisms of action, dosing in therapeutic use and the consequences of toxic doses as outlined in AttachmentAttachment D[1], Charts A-D.

1) Midazolam

Midazolam is a short acting benzodiazepine which is use as a pre-anesthetic agent for routine medical procedures to allay patient apprehension, create amnesia, and anesthesia induction. It produces different levels of central nervous system (CNS) depression through binding to gamma-aminobutyric acid (GABA) receptors. It is available in an injectable dosage form. Once the drug is administered the onset of action is 1.5-5 minutes. It is widely distributed after administration and

[1] Attachment D in this report refers generally to the attachment to the Oklahoma Department of Corrections execution protocol identified as OP-040301 with an effective date of 9/30/2014 that identifies specifics regarding the preparation and administration of chemicals for use in the execution of offenders sentenced to death.

crosses the blood brain barrier. Maximum effects are seen in 20-60 minutes with recovery occurring in 2-6 hours. Serious adverse events include cardiac arrest, agitation, apnea and respiratory depression/arrest. The drug can result in depression of the spinal reflexes and reticular activating system leading to coma and respiratory arrest. The drug will potentiate the effect of other central nervous system depressants, such as ethanol, opioids and sedative hypnotics. When given together with opioids, the dose of both drugs can be reduced. The therapeutic dose as a pre-anesthetic for adults is 1.5 – 3.5 mg for a 70kg adult less than sixty years old with a maximum recommended dose of 5mg intravenously. The maximum daily dose should not exceed 10mg. When the drug is used for induction of anesthesia no more the 40 mg. should be used. Fatalities have occurred from midazolam in doses ranging from 0.04 to 0.07mg/kg. (2.8 – 4.9mg/70Kg adult)

The dose indicated in Charts C & D of Attachment D of the State of Oklahoma's execution protocol is 500 mg IV. This dose is at least 100 times the normal therapeutic dose. When the drug is administered rapidly in this large dose it will lead to toxicity resulting in CNS depression, respiratory and cardiac arrest. Midazolam is not an analgesic however the dose administered per Chart B will render the person unconscious and "insensate" during the remainder of the procedure. The lowest dose resulting in human deaths according the manufacturer's "material Safety Data Sheet" is .071 mg/kg, intravenously. Over 80 deaths from the use of midazolam had occurred as of 2009.

2) Pentobarbital

Chart A of Attachment D calls for the use of pentobarbital. This drug is a short-acting oral or parenteral barbiturate having sedative-hypnotic and anticonvulsant properties. In general, the drug has a nonselective depressant effect throughout the central nervous system due to a decrease in both pre- and postsynaptic excitability. The sedative-hypnotic effects of pentobarbital are related to its inhibition of ascending conduction in the reticular formation, which controls central nervous system arousal. The inhibition depresses the sensory cortex: decreases motor activity; alters cerebral function; and increases the threshold for electrical stimulation, which contributes to its anticonvulsant properties. It has been suggested that the sedative-hypnotic and anticonvulsant effects of barbiturates may be due to their ability to mimic the inhibitory synaptic action of gamma-aminobutyric acid.

Historically, the drug was used to induce a coma characterized by absent brainstem reflexes and suppression of the EEG for patients with status epilepticus, acute eclampsia or poisoning. In order to use the drug this way, patients had to be mechanically ventilated first and a loading dose of 10-15 mg/kg IV for 1 hour with the maximum loading dose of 30mg/kg would be used. The onset of action of pentobarbital is about 1 minute following intravenous dosage. Therapeutically the drug should not be administered at rate higher than 50 mg/minute with at total dose 200-500mg. Chart A calls for 5,000 mg to be administered in an IV bolus (as rapidly as possible).

Adverse Drug Reactions (selected): Apnea, respiratory depression, hypoventilation, bronchospasm, hypotension, sinus tachycardia, syncope and vasodilatation leading to cardio-pulmonary collapse may occur with rapid intravenous (IV) administration of pentobarbital.

When the drug is administered in accordance with Chart A it will lead to toxicity resulting in cardiopulmonary collapse.

3) Sodium Thiopental (Pentothal®)

Chart B of Attachment D of the State of Oklahoma's execution protocol calls for the use of sodium thiopental. Thiopental is used to induce general anesthesia prior to administration of other anesthetic agents or as the sole anesthetic agent for short surgical procedures. It is a barbiturate which had dose related hypnotic effects ranging from light sleep to unconsciousness and anterograde amnesia but no analgesia. Thiopental works by enhancing GABA activity by altering inhibitory synaptic transmissions mediated by $GABA_A$. Onset of activity occurs in 10-40 seconds with maximal effects occurring in about one minute. The duration of action is 5-8 minutes after a single dose. This can be extended with continuous IV administration. Doses required to induce and maintain anesthesia are 50-75mg (2-3 m Lof a 2.5% solution) administered every 20-40 seconds with additional drug administered should the patient's anesthesia lighten. Alternatively, anesthesia could be rapidly inducted with a bolus dose of 210-280 mg (3-4 mg/kg) given in 2-4 divided doses in an average 70 kg adult.

Thiopental could induce respiratory depression leading to decreased ventilator response to carbon dioxide. Myocardial depression could occur resulting in arrhythmias, increased heart rate, circulatory depression and death. Oklahoma's execution protocol Attachment D Chart B calls for 5 grams to be injected all at once which is over 20 times the dose for rapid induction which is given in divided doses. At this dose and rate of injection cardiopulmonary arrest will occur.

4) Hydromorphone

Chart C of Oklahoma's execution protocol calls for the use of Hydromorphone Hydrochloride (Dilaudid®). The drug is an opioid agonist. It is a semisynthetic analog of morphine used to relieve severe pain in in cancer, surgery, trauma, burn, and cardiac patients. Fatal cases of respiratory arrest have occurred even when the drug was used as recommended and not misused or abused. The FDA has required a "black box warning" concerning the dangers of the drug regarding fatalities secondary to the drug's use to be included in the manufacturer's package insert.

It is a potent mu (OP3) receptor agonist. Mu receptors couple with G-protein receptors and function as modulators, both positive and negative, of synaptic transmission via G-proteins that activate effector proteins. Analgesia is mediated through changes in the perception of pain at the spinal cord and in the central nervous system. Opioids close N-type voltage-operated calcium channels and open calcium dependent inwardly rectifying potassium channels resulting in hyperpolarization and reducing neuronal excitability. Opiates do not alter afferent nerve

stimulation secondary to noxious stimuli. They do however blunt the emotional response to pain.

Clinically, stimulation of mu receptors produces analgesia, respiratory depression, miosis, decreased gastrointestinal motility, and physical dependence. Respiratory depression is caused by direct action on the respiratory centers of in the brain stem. A reduction in the responsiveness of the brain stem to carbon dioxide and electrical stimulation occurs.

Since the respiratory center is severely depressed at high doses of hydromorphone, it does not respond to increasing levels of carbon dioxide and therefore, there is no urge to breathe (no "air hunger").

In clinical use, 0.2 to 1 mg IV may be administered over at least 2-3 minutes every 2-3 hours as needed for pain. In the opiate naïve patient, the dose is initiated at the lowest possible amount and titrated upwards to obtain pain control. With appropriate titration there is no maximum dose. Duration of action is 4-5 hours.

Intravenous administration drug distribution has two half-lives with the initial half-life being 1.27 minutes followed by 14.7 minutes. The first half-life is the time to reach equilibrium in the plasma and the second half represents the distribution to other tissues.

Drug elimination is through hepatic and renal mechanism; therefore the dose would be reduced for patients with diminished hepatic or kidney function. The primary metabolite of hydromorphone is hydromorphone-3-glucuronide which has

35-40 times greater exposure than parent compound. The time it takes to eliminate half of an administered dose is 2.3 hours.

These properties indicate that the drug has a very quick onset of action with its peak pharmacological effect occurring within 15 minutes. The majority of the drugs effect is seen quickly after administration via the intravenous route.

At therapeutic doses, cardiovascular adverse effects include: sinus bradycardia (<2%), sinus tachycardia (<2%), palpitations (<2%), hypertension, hypotension, orthostatic hypotension, faintness, flushing, extrasystoles (<2%), and syncope. In cases of severe respiratory and/or circulatory depression, shock and cardiac arrest may occur.

An overdose causes respiratory depression, extreme somnolence, stupor or coma, skeletal muscle flaccidity, cold and clammy skin, bradycardia, hypotension apnea, circulatory collapse, cardiac arrest and death.

Chart C of Oklahoma's execution protocol calls for 500mg of hydromorphone (500 times the IV dose) administered IV in a bolus. This dose and speed of administration in combination with the hydromorphone administered will lead to cardiopulmonary collapse.

5) Paralytic Agents

Chart D of Oklahoma's execution protocol calls for the use of a paralytic such as vecuronium bromide, pancuronium bromide or rocuronium bromide. These agents are neuro muscular blocking agents that are clinically used to as adjuncts to general anesthesia providing skeletal muscle

relaxation during surgery or mechanical ventilation. They work by binding to acetylcholine receptors but do not activate them. All three of these paralytics have the same mechanism of action and may be used interchangeably taking into differences in dosing, length of action and some differences in side effects.

Drug	Dose	Onset	Duration	Recovery	Vagal Block
Pancuronium	0.05 mg/kg	2-3 min	90-100 min	120-180 min	Modest to marked
Vecuronium	0.05mg/kg	1-1.5 min	35-45 min	45-60 min	No
Rocuronium	0.3 mg/kg	2 min	30 min	20-30 min	Some at higher doses

The typical initial dose of vecuronium bromide for a 70 Kg individual to achieve skeletal muscle relaxation would range from 5.6to 7 mg in adults. Chart D of Oklahoma's execution protocol calls for 100 mg of vecuronium bromide or equivalent dose of either of the other agents. This dose is approximately 20 times the normal dose in skeletal muscle relaxation and will achieve the desired effect at a very high confidence level.

6) Potassium Chloride Injection

Potassium is the major cation of body cells (160 mEq/liter of intracellular water) and is concerned with the maintenance of body fluid composition and electrolyte balance. Potassium participates in carbohydrate utilization, protein synthesis, and is critical in the regulation of nerve conduction and muscle contraction, particularly in the heart.

Recommended administration rates should not usually exceed 10 mEq/hour or 200 mEq for a 24 hour period if the serum potassium level is greater than 2.5 mEq/liter.

The signs and symptoms of intoxication include, paresthesia of the extremities, are flexia, muscular or respiratory paralysis, mental confusion, weakness, hypotension, cardiac arrhythmia, heart block, electrographic abnormalities and cardiac arrest.

Reactions which may occur because of the solution or the technique of administration include febrile response, infection at the site of injection, venous thrombosis or phlebitis extending from the site of injection, extravasation and hypervolemia.

Chart D calls for 240 mEq of potassium chloride to be administered intravenously as rapidly as possible. The dose is 24 times that is recommended over a one hour period. This dose will induce a cardiac arrest.

7) Involuntary Movements

Some involuntary motor movements may be observed during normal anesthesia and have been observed during execution by injection. It is also postulated that when the brain is deprived of oxygen, movements are a result of hypoxemia. "Most of the movements described in brain-dead patients are considered spinal reflexes. The pathophysiologic basis of these reflexes is not known. However, hypoxic stimulation of neurons in the cervical spinal cord, isolated from the control of rostral areas, can elicit spinal reflexes. This hypothesis is supported by the appearance of spinal movements after a ventilator is turned off or during apnea testing. Other triggering factors—such as mechanical or painful stimuli, hypotension, and acidosis—have also been associated with spinal reflexes. Movements with

muscular origin, such as eye opening or facial myokymia, have also been described." (Saposnik, G. Spontaneous and reflex movements in 107 patients with brain death. The American Journal of Medicine (2005) 118, 311-314).

8) Can the subject feel pain?

Excluding potassium chloride, none of the drugs in question causes pain upon injection. When high dose pentobarbital, thiopental, hydromorphone or midazolam are used in the amounts specified in Attachment D, the subject quickly reaches an unconscious and unresponsive state and would not react to painful stimuli. As specified in Attachment D, a consciousness check is conducted after 5 minutes have elapsed following the administration of the first chemical. Even so, the proper administration of of 500 mg of midazolam as specified in Chart D, make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from application of the 2nd and 3rd drugs in that Chart.

7) Benzyl Alcohol

The addition of benzyl alcohol to pharmaceutical preparations is for its bacteriostatic properties. In midazolam solution for injection, there is 1% benzyl alcohol. By volume the amount of benzyl alcohol would be 1 ml contained in 100m1 of midazolam for injection. Most complications reported with benzyl alcohol have been in premature infants and a few cases in adults who have serious medical conditions. A 4.5 mg/kg dose is considered safe for health adults.

Respectfully Submitted,

/s/ R. Lee Evans
R. Lee Evans, Pharm.D.,
FASHP, FCCP, BCPP
Dean and Professor

Selected References:

WWW.Drugs.Com (for health professionals) for Thiopental. Pentobarbital, Hydromorphone, Potassium Chloride, Midazolam, Vecuronium Bromide, Pancuronium Bromide or Rocuronium Bromide

Material Safety Data Sheet for Midazolam Injection, Bedford Laboratories, 2007.

Clinical Practice Guidelines for Sustained Neuromuscular Blockade in the Adult Critically Ill Patient. ASHP Therapeutic Guidelines. American Society of Health System Pharmacists, 2001

Final Report on the Safety Assessment of Benzyl Alcohol, Benzoic Acid, and Sodium Benzoate. International Journal of Toxicology 2001:20;23.

Benzyl Alcohol. PubChem.ncbi.nlm.gov, compound/benzyl_alcohol.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-665-F

CHARLES F. WARNER, ET AL.,

Plaintiffs,

vs.

KEVIN J. GROSS, ET AL.,

Defendants.

TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING BEFORE THE HONORABLE STEPHEN P. FRIOT UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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* * * *

[629] Honor.

THE COURT: Okay. You may proceed.

And as soon as anybody—I'm going to go closer to 3:00, unless somebody requests a recess before 3:00. And if that request is made, that's what we'll do.

ROSWELL LEE EVANS,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MR. HADDEN:

Q. Good afternoon, Doctor.

A. Hi.

Q. Doctor, if you would, briefly just go over your—some of your highlights of your CV. The judge has already indicated he's read it, so we don't need everything. But just give the highlights so we can—

THE COURT: For the record, let's have his full name.

THE WITNESS: My full name is Roswell Lee Evans, Jr.

THE COURT REPORTER: Could you spell your first name, please.

THE WITNESS: Evans, E-V-A-N-S.

THE COURT REPORTER: First name?

THE WITNESS: Roswell, R-O-S-W-E-L-L.

Q. (BY MR. HADDEN) And if you would, just briefly go over your CV, Doctor.

A. Okay. I have a pharmacy degree at a bachelor's level.

[630] Q. Okay. I'm sorry. Just keep going.

A. Okay. A doctor of pharmacy degree from the University of Tennessee, a residency from the Medical University of South Carolina. I joined the faculty at UT, University of Tennessee Health Sciences, began a specialty in psychiatry. Left UT, went to the University of Missouri, Kansas City, as a member of the Department of Psychiatry and the School of Pharmacy. Eventually developed a post-graduate residency and fellowship training and research program. Became department head. Subsequently left

and went to Auburn as the Dean of the School of Pharmacy.

Q. And is that where you are currently employed?

A. I am currently there, yes.

Q. Doctor, as part of your training and experience, are you limited to the normal range of research and activities that most PharmDs are?

A. Yes.

Q. Do you also do additional things beyond what a normal PharmD might do?

A. I'm a board-certified psychiatric pharmacist, so I have certainly been involved in activities that were a little bit more progressive than most practitioners. That's changing today, however.

Q. Okay. Have you been present during medical procedures from time to time where drugs were being introduced?

[631] A. Yes.

Q. Have you been present during some where there was induction of anesthesia?

A. Yes. But that was typically—not something that was very common for me. I've probably experienced more of that personally than I've seen.

Q. Okay. And if you would, Doctor, let's go ahead and turn to your report, which is—

A. I have a copy.

Q. —Plaintiffs' 34. Do you have it there, Doctor, in front of you?

A. Yes.

Q. Okay.

MR. HADDEN: It's Defendants' 34, Your Honor, if you have a copy. Actually, we also gave you one like this. I don't know which one you have.

Q. (BY MR. HADDEN) All right. Okay, Doctor, if you would, just briefly describe for the Court from your report what midazolam is.

A. Midazolam is a short-acting benzodiazepine. The drug is primarily used as a drug to induce anesthesia, to actually facilitate minor procedures and decreases apprehension, also decreases memory of the event.

Q. And, Doctor, is—to your knowledge, is midazolam always used with an analgesic?

[632] A. No, not always. In clinical procedures that just require somebody to be sedated or quick procedures that are not necessarily terribly invasive, it could be used by itself. Medical procedures typically use it. I mean, even for something like a colonoscopy, you would see it used in combination with a narcotic.

Q. Okay. Are there procedures, though—if you would, describe some of the procedures where you may use midazolam without an analgesic.

A. Well, oftentimes they're used in dental procedures.

THE COURT: In what?

THE WITNESS: Dental procedures. Extractions. And in combination, even there some times with gas or other agents, but oftentimes by itself the—they're typically fairly minor medical procedures that are—where the drug is used.

Q. (BY MR. HADDEN) Okay. Doctor, in your report and in your section on midazolam, you talk

about therapeutic doses. Do you see that, about halfway down, it starts, "The therapeutic dose"?

A. Yes.

Q. If you would, just read that sentence for me, please.

A. A therapeutic dose as a preanesthetic for adults, is 1.5 to 3.5 milligrams for a 70-kilogram adult less than 60 years of age with a maximum recommended dose of 5 milligrams intravenously.

[633] Q. Doctor, what do you mean by "therapeutic dose"?

A. Well, a "therapeutic dose" is primarily a dose that's use to achieve a specific outcome, as in sedation, and/or developing amnestic properties for—to prevent people from remembering the procedure, even to the point where they don't remember things that might even be somewhat painful.

Q. Okay. So if you were going to use it for a non-therapeutic purpose, you could use a great deal more than what you have listed here, couldn't you?

A. Absolutely.

Q. Now, in that last line of that paragraph, Doctor, if you would, read that where it starts, "Fatalities."

A. "Fatalities have occurred from midazolam and doses ranging from .04 to.07 milligram per kilogram."

Q. All right. And where did you extract that information from, Doctor?

A. Actually, that came from the manufacturer's product sheet

Q. Are you aware of any studies or reports that indicate that there have been some deaths from the use of midazolam?

A. There have been at least 80 case reports of fatalities in the country from midazolam, the use of midazolam.

Q. Do you know whether those were at therapeutic doses or much higher doses?

A. No, that part is unclear. I think most of the time they were used in therapeutic doses.

[634] Q. Okay. Now, Doctor, midazolam, can it be utilized to take someone to an unconscious state?

A. Yes, it can.

Q. And if a proper IV access is obtained and there is an infusion of midazolam, could you achieve that unconscious state without the use of an analgesic?

A. Yes.

Q. And if you achieve that unconscious state, would an analgesic be necessary?

A. No.

Q. So if someone were to criticize and say that Chart D of Attachment D of the Oklahoma protocol is ineffective because it does not include an analgesic, would you agree with that?

A. No, I would not.

Q. In your opinion, Doctor, if proper IV access is obtained and 500 milligrams of midazolam is introduced intravenously, will that subject become unconscious at some point?

A. Yes.

Q. If you also couple that with a wait of five minutes and a consciousness check by a medical professional, are you assuring that they are, indeed, unconscious before proceeding?

A. Yes.

Q. Now, I'd like to direct you, then, to that next paragraph there that starts with, "The dose." If you would, just read that paragraph or—I'm sorry, not the paragraph. Just that [635] sentence.

A. "The dose indicated in Chart C and D of Attachments D of the State of Oklahoma's execution protocol is 500 milligrams IV."

Q. And go ahead, if you would, read that one next sentence.

A. "This dose is at least 100 times the normal therapeutic dose."

Q. And how did you determine it was at least 100 times over the therapeutic dose, Doctor?

A. Well, the normal therapeutic dose is anywhere up to 3-and-a-half milligrams at one time. And anywhere from 1-and-a-half to 3-and-a-half, so it's a pretty good dose.

Q. Okay. So if someone were to differ with you that it's not 100 times, could it just be that they have a different definition of precisely what a "therapeutic dose" is? A. Right.

Q. If you would look down, then, to the sentence that begins, "Midazolam is not an analgesic."

A. Right.

Q. Go ahead and read that one, if you would.

A. "Midazolam is not an analgesic, however, the dose administered per Chart B will render the person unconscious and insensate during the remainder of the procedure."

Q. Now, Doctor, I don't know if you have the copy I do, but this one says "Chart B." Does that mean Chart D?

[636] A. Did I say "D" (sic)? I need new glasses. It's Chart D.

Q. It may be a typo. I'm not sure. I just want to make sure we're on the right track.

A. I think it's a typo.

Q. Okay. So as we're talking about there, do you stand by that statement?

A. Yes.

Q. So if someone was critical and said that that is an untrue statement because there is a "ceiling effect," would you agree with that statement?

A. No.

Q. And why is that?

A. The "ceiling effect" that's been referred to is an effect specifically on the spinal cord, and there are studies to show that, you know, you can eliminate a significant portion of an inhaled anesthetic with the use of midazolam, but you can't completely eliminate it, and that's really to maintain a plane of surgical—a surgical plane, and that's all at a spinal cord level.

What we're talking about here is at the reticular activating system, the part of the brain that controls respiration, so we're basically shutting down

respiration centers. There is no ceiling effect at that level.

Q. Okay. Now, Dr. Lubarsky testified the other day about GABA receptors.

[637] THE COURT: When you say "at that level," what level are you referring to?

THE WITNESS: At that part of the brain, the higher level of brain. So the spinal cord is a lower part of the central nervous system. The brain itself, the reticular activating system is the part of the brain that controls respiration. And so this dose is essentially shutting down that system.

THE COURT: "This dose" being?

THE WITNESS: 500 milligrams of midazolam.

Q. (BY MR. HADDEN) Doctor, there's some discussion today from Dr. Lubarsky about GABA receptors. Do you know what those are?

A. GABA receptors? Yes.

Q. Could you just explain briefly, how does that—how does midazolam interact with GABA receptors?

A. Midazolam attaches to GABA receptors, inhibiting GABA. And that's generating us—that's what generates the clinical effect or the pharmacological effect from midazolam and all the other benzodiazepine drugs, as well as some other agents as well.

GABA is a—GABA receptors are found across the entire body, so there are GABA receptors on the spinal column and there's GABA receptors in the brain.

And so what we're doing—GABA, for instance, is responsible—GABA receptors are responsible for

anxiety [638] disorders. So when you basically inhibit GABA, you basically begin to control those kind of symptoms.

Q. And does anyone reliably know how many GABA receptors are even in a human body?

A. No.

Q. Can you even take a guess? I mean, are we in the millions, billions? What are we in?

A. In the millions.

Q. So Dr. Lubarsky today had a somewhat simplified but seemingly effective representation of a building with doors and people holding the doors open. Have you heard that kind of explanation before?

A. No.

Q. Okay. Well, I'm paraphrasing here, and I may have it a little bit wrong, but the way I recall it was simply that you have a number of doors and you're not going to get any more effect if a hundred people hold those doors open than if two people do as people come in. Is that effective representation at all?

A. What he's talking about is the competitive nature of substances trying to attach to GABA receptors. You know, in certain parts of the body, that may be a major issue, but we're talking about instead of three or four doors, we're talking about lots and lots of doors, so it's—it's an interesting analogy, but the numbers are quite large.

[639] Q. So if we were to use his representation and were picturing a courthouse, we should instead be picturing maybe a building the length of the United States with doors along it?

A. Or at least all the doors in the city of Oklahoma City.

Q. Okay. Now, Doctor, in terms of the effects of midazolam, you said it goes beyond just affecting the spinal column; is that true?

A. That's true.

Q. And what other parts of the central nervous system does it affect? Does it affect all of them?

A. Yes.

Q. And are there GABA receptors along the entire length of the central nervous system?

A. Yes.

Q. And does it affect all of those?

A. Yes, it does.

Q. Okay. And if you effectively—I guess I should rephrase that. If you affect enough GABA receptors along the length of that central nervous system, will you obtain a level of unconsciousness?

A. Well, yes, you will. And especially at the central nervous system—higher levels of the central nervous system, the brain itself. You're basically—in many ways, you're paralyzing the brain. It no longer functions. Especially the [640] respiratory centers.

Q. But would it also paralyze the pain centers?

A. It may not paralyze the brains—the pain centers in the brain, but the individual would (sic) be able to respond to that, would not be aware of it.

Q. So this has some amnesic qualities, I think you said earlier?

A. It does have amnestic qualities, yes.

THE COURT: You say the individual would or wouldn't be able to respond to it?

THE WITNESS: Would not be able to respond.

THE COURT: Okay.

THE WITNESS: Essentially we're achieving a state of unconsciousness very quickly.

Q. (BY MR. HADDEN) And just to be clear, you're saying they would not sense the pain?

A. Would not sense the pain, no.

Q. And, Doctor, have you heard of the paradoxical effect regarding midazolam before?

A. Yes.

Q. There was some commentary over the last few days that it's not reflected in your report anywhere. Is there a reason for that?

A. Well, I don't think it's a significant issue in this particular circumstance. The doses that we're seeing, you [641] really don't see a paradoxical effect. You do at lower doses. It's probably less than 1 percent of low dose, therapeutic dose, that you would see anyone that would have a paradoxical effect, which is a pretty low percentage for any side effect.

Q. Okay. And when you say—are there studies about the paradoxical effect, Doctor?

A. No, there are case reports. There are really no studies that I'm aware of.

Q. Okay. In these case studies, again, what are you talking about, low doses? Are we talking about low therapeutic doses?

A. Low therapeutic doses, right.

Q. So if you previously testified therapeutic doses in the—

A. One-and-a-half to 3-and-a-half.

Q. So we're talking in that 1-and-a-half milligram range?

A. Right. I should add, though, that that's also a very slow administration rate.

Q. Okay. Dr. Evans, you previously testified in the Chavez case in Florida?

A. I did.

Q. Did Dr. Lubarsky testify in that case?

A. Yes, he did.

Q. Was that protocol involving the same protocol as Method D in Oklahoma's current protocol?

A. Yes.

[642] Q. And was that ultimately found constitutional?

A. Yes.

Q. All right. Doctor, let's look back, if we could, please, at your report on page 2. You have some commentary there and some ultimate determinations on pentobarbital and on sodium thiopental. If you would, just read the last sentence under "pentobarbital," please.

A. "When the drugs administered in accordance with Chart A will lead to toxicity resulting in cardiopulmonary collapse."

Q. And is that still your opinion today, Doctor?

A. Yes.

Q. Then look down, if you would, to Section 3 and the last sentence of that one as well.

THE COURT: Wait, wait, wait.

MR. HADDEN: I'm sorry.

THE COURT: You were looking in paragraph 2 on the second page of your report; is that right?

MR. HADDEN: Yes, Your Honor. I've just asked him to read the last paragraph of the Section 2.

THE COURT: Okay. Very good. Proceed.

Q. (BY MR. HADDEN) And then, if you would, the last sentence of Section 3 as well.

A. "At this dose and rate of injection, cardio-pulmonary [643] arrest will occur."

Q. Now, those two drugs, pentobarbital and sodium thiopental, those are what class of drugs?

A. Barbiturates.

Q. Okay. Let's move on, please, to Section 5, which you talk about paralytic agents?

A. Yes.

Q. Now, Doctor, in that section, you have discussion of three different agents and a chart. And I did want to ask you first: Why did you select these three separate particular drugs?

A. Well, they're ones that are referred to in the protocol. They're non-polarizing paralytic agents. And essentially they're equivalent in terms of the way they work.

Q. So what is the difference between them, Doctor?

A. The difference tends to be duration and recovery time. For instance, on rocuronium bromide,

recovery time is much shorter, 20 to 30 minutes, in comparison to pancuronium bromide, which is recovery time at 120 to 180. That's important if you are doing surgical procedures and somebody is going into recovery.

Q. Okay. In terms of dosage, Doctor, if one was calculating a dose for someone, the items you have under "dose" is how they would calculate it?

A. Yes.

[644] Q. So as I'm looking at those, it looks like pancuronium and vecuronium, you need slightly more than you do for rocuronium;, is that correct?

A. Right.

Q. Now, when you examined Chart D of the execution protocol, do you believe that the amount specified in Chart D is sufficient to function as a paralytic?

A. Yes, it's 20 times what you actually need to get an effect.

Q. Okay. And the same for the rocuronium, would that be—

A. That's true.

Q. So if you use the same dosage in terms of milligrams, you get the same effect no matter which one you chose?

A. Yes.

Q. Looking on, Doctor, to Section 6, potassium chloride?

A. Yes.

Q. Actually, let's look at the last—the next page, the last line in that. And just—let's see, just go ahead and start there at Chart D. That may be the—

A. Chart D calls for 240 milliequivalents potassium chloride to be administered intravenously as rapidly as possible. The dose is 24 times that that is recommended over a one-hour period. This dose will induce cardiac arrest.

Q. Okay. So if the intent—

THE COURT: Excuse me just a minute. Just for the [645] record. You referred to 240 milliequivalents?

THE WITNESS: Yes.

THE COURT: That's what the "mEq" stands for?

THE WITNESS: Right.

THE COURT: Proceed.

Q. (BY MR. HADDEN) Just if you would, jut briefly, what is the expression "mEq"?

A. It's basically a measure of ion, the ion potassium itself.

Q. And is that a normal way of expressing a dosage of potassium chloride?

A. Electrolytes, yes. Normal way of expressing electrolytes.

Q. Okay. So is it your testimony that that—the dosage called for in Chart D is sufficient to cause cardiac arrest in the offender?

A. Yes.

Q. Doctor, in Item 7 you also have a section on involuntarily moments. Do you see that?

A. Yes.

Q. Have you, in fact, read some reports regarding involuntary moments?

A. Yes.

MS. KONRAD: Objection. Just for the record, restating the objection based on the motion in limine we filed.

THE COURT: Very well. That's understood. [646] Proceed.

Q. (BY MR. HADDEN) Have you read some research reports regarding involuntary movements?

A. Yes.

Q. And after reading those, what conclusions have you drawn?

A. Well, I think the primary conclusion about involuntary movements is the fact that when you begin to shut off the oxygen supply, you're going to get some involuntary movements because the body is beginning to, if you will, adjust and react to that, so I think any time there is a hypoxemia or low oxygen levels, you could begin to see involuntary movements.

So those things have been described in the literature for some time anecdotally and there's at least one study who is looking at it with—that's mentioned here and that's Saposnik study.

Q. Okay. So when we're talking about involuntary movements, we're specifically talking about someone going through a death process, as opposed to just being anesthetized for a medical procedure, correct?

A. Right.

Q. Isn't that similar to what's intended with an execution process, Doctor?

A. Yes, it is.

Q. Moving on, Doctor, for Item 8, about pain, if you would look at that, please.

[647] A. Yes.

Q. Go ahead and read that first sentence, if you would, please.

A. "Excluding potassium chloride, none of the drugs in question causes pain upon injection."

Q. Now, specifically, what are you talking about there, Doctor? Are you talking about the drug or the injection itself?

A. No, the drug itself as it's being injected, potassium chloride is a fairly caustic drug, and so when it's injected, it can cause some inflammation and pain.

Q. Okay. But in terms of the paralytic, there is not any pain associated with that?

A. There's no pain associated with the paralytic.

Q. And with the midazolam, there's not pain associated with that?

A. There's no pain associated with midazolam either.

Q. And go ahead, if you would, read that second line for us, Doctor.

A. "When high-dose pentobarbital, thiopental, hydromorphone or midazolam are used in amounts specified in Attachment D, the subject quickly reaches unconscious and unresponsive state and would not react to painful stimuli."

Q. And how did you come to that conclusion, Doctor?

A. It's essentially that you have shut down the brain [648] entirely and it's basically not responding to afferent stimuli. And so I think with that kind of dose and the achieved effect of 500 milligrams of midazolam or one of these other substances, you're really not going to see the pain piece. This is particularly in the event that—or with a procedure where you're administering a very large dose of this drug very rapidly.

Q. Go ahead, then, Doctor, if you would, read that last part, beginning at, "Even so."

A. "Even so, the proper administration of 500 milligrams of midazolam, as specified in Chart D, make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs in the chart."

Q. Okay. So to the extent there is a noxious stimuli from the second and third drugs in the chart, Doctor, in your opinion, would that be alleviated by the use of the midazolam, as specified in Chart D, a wait of five minutes and a consciousness check by a medical professional?

A. Yes. I think that would prevent the reaction, the painful stimuli.

Q. Now, Doctor, in that line that you just read about the proper administration, are you presupposing a—obtaining proper IV access?

[649] A. Yes.

Q. So if proper IV access is achieved, that statement in your opinion would be true?

A. Yes.

Q. One more thing, Doctor. In terms of paragraph 7 and 8 taken slightly together, in your opinion, based upon the studies that you have read, if you were to see involuntary movement, such as were described in this research study you cite there, is that necessarily indicative of a subject feeling pain?

A. Not necessarily, no.

Q. Doctor, there was a—

THE COURT: How much do you lack on direct?

MR. HADDEN: I'm sorry?

THE COURT: How much more do you have on direct?

MR. HADDEN: Maybe 15, 20 minutes, Your Honor. Maybe we want to go ahead and take a break for the—

THE COURT: We'll take our mid-afternoon break at this time. We'll resume at 3:30. Because of another situation, it may be slightly after 3:30, but we'll shoot for resuming at 3:30. Court will be in recess.

(RECESS HAD.)

THE COURT: Mr. Hadden, you may continue.

MR. HADDEN: Thank you, Your Honor.

[650] Q. (BY MR. HADDEN) Doctor, Dr. Sasich testified yesterday about a report that he cited in his expert report on perception of pain. Are you familiar with that report?

A. Which one was it?

Q. I'm sorry, it's footnote—

A. Four?

Q. Do you have his report somewhere there, Doctor?

A. No, I don't. Unless it's—

Q. Plaintiffs' 77. Okay. Its on the monitor there, Doctor.

A. Oh, thank you.

Q. If we can just go to page 4—no, the next one, please. Down at the bottom, Footnote 3.

A. Yes.

Q. Are you somewhat familiar with that report, Doctor?

A. Yes, I am.

Q. Okay. If you just could briefly explain what that report is about.

A. The Frolich study was a—I believe, without looking at the article itself, was a dog study in which there was a—an attempt to determine if the midazolam could substitute for inhaled anesthesia.

Q. And you said it was done on dogs?

A. Yes.

Q. Do you know where that study was done?

[651] A. If I'm remembering the study correctly.

Q. Okay. Do you know where that study was done?

A. Where it was done?

Q. Yes.

A. I think the study was actually done at University of—UAV in Alabama.

Q. Okay. And then if you look down at Footnote 4 there, are you aware of or familiar with that study, Doctor?

A. Yes.

Q. Okay.

A. That publication was a general review of benzos in the use of anesthesiology.

Q. Okay. And in your opinion, Doctor, does that—Report 4, does that support his comment there about the ceiling effect?

A. There is one sentence that mentions the ceiling effect and that actually does not support the—a ceiling effect. It refers to—eventually it refers back to an '88 article that was done looking at a ceiling effect. And I think that's the study I just cited that's not the one that the other author, Frolich, did.

Q. Okay.

A. But this one—the '88 study was a study looking at substitution of midazolam for inhaled anesthesia.

Q. Okay. Doctor, there was some criticism of drugs.com by Dr. Sasich. What's your knowledge of that source?

[652] A. Well, drugs.com is—really a tertiary resource that is a combination of materials pulled from some of the most outstanding references in the country that have been around for 50-plus years, one being the American Society—I mean, American Hospital Formulary Service, Facts & Comparisons, a number of other routine very reliable resources, and so it's—the professional version of that is pretty useful information and it really does outline—in this case, these medications have been around long enough that

most of the things that are there are things that everybody knows.

Q. Okay. Doctor, so as a source for the medications that are well-known, as you're saying, it is reliable in your opinion?

A. Yes.

Q. Doctor, just one final question for you. In your opinion, would Chart D of Attachment D of the Department of Corrections' policy that you reviewed, in your opinion, does that carry a substantial likelihood of severe pain and suffering if applied correctly?

A. Not if it's applied correctly, no.

MR. HADDEN: No further questions, Your Honor.

THE COURT: Cross-examination.

CROSS-EXAMINATION

BY MS. KONRAD:

Q. Good afternoon, Dr. Evans. I'd like to turn your attention now to the screen here.

[653] A. Yes.

Q. You just testified regarding a Footnote 3—

A. Right.

Q. —that was cited in Dr. Sasich's report. And it was a study called the Effect of Sedation on Pain Perception, and you just indicated that that was a dog study; is that correct?

A. Yes. And I corrected myself. That wasn't the dog study. I'm very familiar with—I'm familiar this article, I just didn't have the article in front of me.

Q. Okay. So this is—was a human-based study, correct?

A. Yes, it was. It was a human-based study.

Q. Is midazolam FDA-approved as a sole drug to produce and maintain anesthesia in surgical proceedings?

A. No.

Q. Can you cite any specific data or studies that support your opinion that 500 milligrams will render someone unconscious and insensate to the noxious stimuli presented by the second and third drug in the lethal-injection protocol in Oklahoma?

A. There are no studies that have been done and probably could be done administering that much medication, midazolam, to anybody. So this is essentially an extrapolation from a toxic effect. We really are not talking about a clinical effect. We're talking about inducing a toxic reaction.

Q. And what do you mean by "toxic reaction"?

[654] A. In this case, that much drug, alone, would cause a person to die as a result of respiratory arrest, so it's more than enough drug to make that happen.

Q. And in your opinion, how long would that take for somebody to die from 500 milligrams of midazolam?

A. By itself?

Q. Yes.

A. Less than an hour. More like probably 30 minutes.

Q. And what data do you have to support that?

A. The data that I have in that regard is the pharmacological impact of midazolam in the respiratory centers of the brain, which are very immediate. The drug is highly soluble and crosses the blood-brain barrier very quickly, so we would see a full effect of that drug very soon after administration intravenously.

Q. And how soon would you anticipate seeing the effects of 500 milligrams of midazolam being administered?

A. 500 milligrams, you would see an impact in three to five minutes.

Q. And whether it's administered intramuscular or IV?

A. No, IV. Much slower from an IM perspective.

Q. And I want to turn your attention to your report, which—do you have that in front of you, Dr. Evans?

A. I do. I do.

Q. You mention that fatalities have occurred from midazolam

* * * *

[658] fatal?

A. Yes.

Q. And I'd like to look, if you could, turn back to the first page of your report. The last sentence—or I'm sorry. The second to the last sentence of the last paragraph on page 1, you mention that the lowest dose resulting in human death, according to the manufacturer's Material Safety Data Sheet, is .071 milligram per kilogram. Is that accurate?

A. I'm on my second page. Read that sentence again, please, and make sure we're in the same place.

Q. Uh-huh. It's the second to the last sentence on the first page of your report that says, "The lowest dose resulting in human deaths, according to the manufacturer's Material Safety Data Sheet," which we were just looking at, "is .071 milligram per kilogram intravenously."

A. Oh, I see. You and I are on different pages.

Q. And it's on the screen in front of you.

A. Thank you.

Q. Uh-huh.

A. Now, your question was: Is this correct?

Q. Based on the Material Safety Data Sheet that we were just looking at.

A. Yeah, should be, yes.

Q. And if the material data sheet that we just looked at on [659] page 4 says this toxic dose, which you indicate represents death, is 71 milligrams per kilogram, is your report incorrect?

A. Yes, it is wrong, according to that, because it does reference that Material Safety Data Sheet. It should be 71 milligrams.

Q. So in the earlier sentence that we were talking about, where you said fatalities have occurred from midazolam in doses ranging from .04 to .07 milligrams per kilogram, is that accurate?

A. Yes.

Q. And what are you basing that opinion on?

A. That is coming from—that is coming from some of the resources that are—that's available in drugs.com.

Q. So I thought you had just told me that you had—you had indicated that the fatalities that have occurred from midazolam came from the Material Safety Data Sheet. Now you're saying they come from drugs.com.

So I'm just trying to be clear about your opinion, because this is a contested opinion, Dr. Evans.

A. Sure.

Q. So I want to make sure that we're getting the correct data.

A. There—there is—there is an inconsistency with the range of .04 to .07 milligram per kilogram with the materials data sheet, and so to be honest with you, I'd have to look at [660] those sources to indicate where that came from, but that was pulled right out of the literature.

Q. Okay. And you said you relied on drugs.com, did you not?

A. Yes.

Q. And—

A. To a large extent, yeah.

Q. There is—attached to your report was a drugs.com printout on midazolam hydrochloride. Was that where you would have gotten that data from?

A. It might have been, yes.

Q. And if you could, you have that exhibit in front of you, and the midazolam printout starts on Bates

Number 6518. If you could please point to me where you got that data from.

A. 6518. This is a long document.

Okay. My quick glance, this is not—may not be the source where this came from.

Q. Okay. What is the source that you are citing that in a 70-kilogram adult, fatalities have occurred from midazolam in doses ranging 2.8 to 4.9 milligrams?

A. Off the top of my head, I can't—I don't recall what that source was.

Q. You say earlier in your report that the therapeutic dose as a preanesthetic for adults is 1.5 to 3.5 milligrams for a 70-kilogram adult less than 60 years old?

A. Right.

* * * *

[663] short-acting drug, so adding something like a narcotic will smooth that piece out.

Q. And you said midazolam is a short-acting drug, and I think you mentioned three to five minutes. Did you consult with anyone in Oklahoma before Mr. Lockett's execution regarding the administration of midazolam?

A. No.

Q. You mentioned the ceiling effect. Is it your opinion that there is no ceiling effect with midazolam?

A. That's not what I said. I said there is not a ceiling effect from effects of the drug centrally to the orders of—higher parts of the brain. On the spinal column, there is.

Q. And what does that mean, that there is not a ceiling effect on the higher parts of the brain?

A. Well, it means that the—as you increase the dose of midazolam, it's a linear effect, so you're going to continue to get an impact from higher doses of the drug.

Q. And is it always a linear impact or is there ever an S curve with midazolam?

A. Could be, because the drug is distributed very quickly within the body, but when you're administering a very large volume of this drug, you're going to get a real big spike in the concentration of blood centrally.

Q. And so do you know whether there is, in fact, a ceiling effect with midazolam?

* * * *

[674] I would like to know what you're basing your opinion on that someone would not react to painful stimuli?

A. Well, if we have induced a state of coma or unconsciousness, it's very much unlikely that anyone is going to react to any painful stimuli, by definition.

Q. Now, as a pharmacist, has a physician ever written an inappropriate drug order?

A. Well, sure.

Q. And if you got an inappropriate drug order from a physician, what would you do?

A. I'd interact with the physician to correct it.

Q. If a physician in a hospital wanted to use midazolam that you knew she was going to use as the

sole anesthetic agent in a painful procedure, what would you do?

A. Well, if it was my service, I would probably advise them not to do that because it's not typical right now. It's not normal practice to do that.

Q. Only because it's not normal, there's no other reason to not use midazolam to induce unconsciousness for purposes of a painful procedure?

A. I would—I think the standard of practice at this juncture would be that a combination would be utilized.

Q. Would you have a painful procedure with only midazolam as the agent to render you unconscious?

A. Would I?

* * * *

[678] RECROSS-EXAMINATION

BY MS. KONRAD:

Q. Have you ever observed an execution in Florida?

A. I have not.

Q. And in Florida, do they give a large dose of a paralytic after injecting the midazolam?

A. Yes.

Q. So if somebody were rendered conscious, they would not be able to move from the paralytic; is that correct?

A. That's true.

MS. KONRAD: No further questions.

THE COURT: You may step down.

MR. HADDEN: Your Honor, I just have one question.

THE COURT: We'll have one more round, then.

REDIRECT EXAMINATION

BY MR. HADDEN:

Q. Dr. Evans, my only question is: In Florida, you are aware they do have a consciousness check before they introduce the paralytic, correct?

A. Yes.

MR. HADDEN: Thank you, Your Honor.

THE COURT: Any re-recross?

MS. KONRAD: No, Your Honor.

THE COURT: You may step down.

THE WITNESS: Thank you.

[679] THE COURT: Do the defendants have any more testimony to present?

MR. HADDEN: Nothing further, Your Honor.

THE COURT: Very well. Anything further from the plaintiffs?

MS. GHEZZI: Your Honor, we would like to have a brief—we would like to have brief closing arguments and maybe a quick break before that, if that's possible.

THE COURT: That's perfectly agreeable. We'll take a 15-minute break and we'll resume at 20 minutes till 5:00. And I would ask you to plan on something in the neighborhood of 15 to 20 minutes apiece. I'm not going to put people under rigid time limits, but please plan on 15 to 20 minutes apiece for your closing arguments.

MS. GHEZZI: Would you have any problem with the plaintiffs breaking their time up initially and then as a—essentially a rebuttal?

THE COURT: That's just fine. Very well. Court will be in recess.

(RECESS HAD.)

THE COURT: We're resuming now with closing arguments in Warner v. Gross. Plaintiffs may proceed.

MR. BAUMAN: Your Honor, I'd like to make just a couple of minutes' worth of comments about the Baze v. Rees

IN THE UNITED STATES DISTRICT COURT
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TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING BEFORE THE HONORABLE STEPHEN P. FRIOT UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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[555] THE COURT: You may step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Let's see, we're still in plaintiffs' case. Sometimes the sequence of witnesses we've had, it's easy to lose track of that. We're still in plaintiffs' case. Do plaintiffs have any further witnesses?

MS. KONRAD: Just one, Your Honor.

THE COURT: Very well.

MS. KONRAD: Plaintiffs call Dr. Eric Katz.

THE COURT: Very well.

ERIC KATZ,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MS. KONRAD:

Q. Good morning, Dr. Katz.

A. Good morning.

Q. Please state and spell your name for the record.

A. Eric Katz, E-R-I-C, K-A-T-Z.

Q. And, Dr. Katz, what is your profession?

A. I am an emergency physician.

Q. And how long have you been an emergency physician?

A. I finished my training in 2000 and I have been practicing emergency medicine since.

Q. And I don't want to go over your entire CV, because the Court already has a copy of it, but I would like you to just [556] give a little bit of background of what you do and what your training entails and what you're doing on a regular basis in your profession.

A. Briefly, I trained in both emergency medicine and internal medicine and became board certified in them shortly after graduating residency.

Since residency, I've been an academic emergency physician and internal medicine physician. I have most recently been the residency director for an emergency medicine residency program.

Currently, I'm the Chairman of Emergency Medicine at Maricopa Medical Center and the University of Arizona College of Medicine in Phoenix.

Q. And what do you do when you're in your residency programs? What do you do in training the students, the residents?

A. All aspects of teaching someone to go from graduating medical school until they are an independent licensed practitioner or emergency medicine.

Q. And does that entail placement of catheters?

A. Yes, it does.

Q. And how often do you do that? How often are you teaching people how to place catheters?

A. We teach courses on it throughout the year. We take every first-year resident and put them through a course on it. We

* * * *

[587] A. Yes.

Q. Does that make sense?

A. I've seen flumazenil have the intended effect.

Q. And have you used any of these drugs with —to reverse the effects of the large doses used in the lethal-injection protocol in Oklahoma?

A. Well, I really don't know what I've seen in the emergency department just simply because I don't know the total amount of drug that's been absorbed into a patient all the time.

Q. Okay. You've reviewed the documentation regarding the execution of Clayton Lockett, including the DPS executive summary, doctor, paramedic accounts and some witness accounts, correct?

A. Yes.

Q. Do you have an opinion whether Mr. Lockett regained consciousness after the doctor determined that Mr. Lockett was unconscious at the seven-minute mark and after he had been administered the 100 milligrams of midazolam?

A. Yes, I do.

Q. And what is your opinion?

A. My opinion is that he was regaining consciousness.

Q. And what is that opinion based on?

A. A few things. The first is that the descriptions that I've seen have included discussion of leg movement followed by the torso moving. And with the exception of the initial report [588] that I saw about the legs, it appeared that both sides of the body were moving.

If this was a seizure or some sort of involuntary activity like that, he would not have been able to speak. And from what I can tell, there are numerous people who said that he either spoke or was trying to form words and speak. If someone is having a seizure, by definition, they can't speak.

I'm sorry, let me clarify that. If someone is having a generalized seizure, which is what it would take to have both sides of the body involved, they would not be able to speak.

Q. And so you also read reports and heard that he was straining against the straps, and I think you listened to Director Patton say that, and Director Patton also said he said the word "man." Are these movements that would be consistent with somebody who was unconscious?

A. No; speaking would not be.

MS. KONRAD: I have no further questions.

THE COURT: Cross-examination.

CROSS-EXAMINATION

BY MR. HADDEN:

Q. All right. Dr. Katz, one of the first things that you testified about was about IV access and attempts to gain IV access. You recall a lot of that testimony, don't you?

A. Yes, sir.

Q. Okay. There was a finding in the DPS executive summary

* * * *

[REDIRECT]

[599] paramedic to be —who were in Mr. Lockett's execution to be used again under those qualifications?

A. Yes, I believe they would.

Q. Based on what you read about their qualifications and the interviews they gave with the DPS?

A. Yes.

Q. And you were also asked the question about, if one is rendered unconscious, will that prevent them from feeling noxious stimuli. Do you remember that question?

A. Yes.

Q. And have you ever used midazolam to render someone unconscious to undergo a surgical procedure?

A. Yes.

Q. And have you used midazolam as a sole agent to render somebody unconscious to undergo a surgical procedure?

A. No, I have not.

Q. And why is that?

A. Because there's no analgesic effect from it, so they would still be feeling the pain from it.

Q. And you were asked about the paralytic vecuronium and whether that would be a noxious stimuli. Do you remember that?

A. Yes, I do.

Q. If one were given the dose that is called for in the Oklahoma lethal-injection protocol of 100 milligrams and they were aware of that, what would the effect be of that?

[600] A. They would be chemically paralyzed and the expression that's sometimes been used for that situation is "locked in," where they're fully awake, they can't move, they can't blink, they can't move on their own.

Q. So if they're not breathing, what would they be feeling?

A. Extreme anxiety, suffocation.

Q. So they would be aware and suffocating because they've been unable to breathe?

A. Correct.

Q. And if somebody was not sufficiently rendered unconscious, but they were paralyzed and not able to breathe, would they be able to feel that?

A. Yes, they would.

Q. And we—Mr. Hadden also asked you about use of ultrasound and the level of training. Can somebody hold an ultrasound for somebody else when they're using it?

A. It can be done, yes.

Q. Is that the general practice when you're using an ultrasound to —for a procedure to set a line, would you hold it yourself or have somebody else hold it for you?

A. It is far preferable to hold it yourself, because you have a very narrow window of view from the ultrasound. The ultrasound window is a 2-millimeter slice, and you have to have your needle within that 2-millimeter slice in order to view it. So having someone else hold it takes away your two-handed

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[39] anything—any action here. And so I'm going to be back here in about five minutes. And court will be in recess.

(RECESS HAD.)

THE COURT: We'll have the plaintiffs' next witness and it is a witness by video.

COURTROOM DEPUTY: Dr. Cohen, can you please raise your right hand to be sworn.

THE WITNESS: Yes.

JOSEPH COHEN,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MS. KONRAD:

Q. Good morning, Dr. Cohen.

A. Good morning.

Q. Can you hear me?

A. I hear you great.

Q. Okay. If there's any delay or any problem with the sound, just let me know and I can repeat the question. Will you please state your name.

A. Yes. My name is Joseph I. Cohen. The first name is J-O-S-E-P-H, middle initial I, last name C-O-H-E-N.

Q. And what is your profession, Dr. Cohen?

A. I'm a forensic pathologist.

Q. And how long have you been a forensic pathologist?

A. Twenty years.

* * * *

[CROSS-EXAMINATION]

[78] A. It is, yes.

Q. How often in your practice do you place an IV?

A. Oh, I don't place IVs anymore. I placed IVs on a daily basis during my surgery training, but not as a pathologist.

Q. How long ago was that, Doctor?

A. It was 1986. So 14, 27 years, 28 years.

Q. Doctor, do you recall reviewing any witness accounts from anyone with medical training that you're aware of?

A. I mean, I think there are some accounts by the paramedic and the physician of record, but I would have to look back and see to what degree they commented.

Q. And based upon what you believe you may have read about the doctor or the paramedics, you still determined that he was not unconscious. Is that what you're saying?

A. That he was what?

Q. That he was not unconscious when declared to be so by the doctor. Is that what you're saying?

A. Well, he was—I believe he was declared to be unconscious and then became conscious to some degree after that.

Q. And how do you determine he became unconscious, Doctor? Based merely upon the witness accounts indicating some degree of movement? Is that what you're saying?

A. Well, the witness accounts that were reported to me that I have here on paper that state Mr. Lockett was moving about, [79] trying to raise his head, trying to get off the table. That, to me, does not equate to unconsciousness.

Q. And if there were other accounts that indicated lesser movement or no movement, you think you would not give those the same weight. Is that what you're saying, Doctor?

A. Not necessarily, no. And I refer to several execution chamber witnesses, is what I perceived

them to be, as opposed to lay witnesses in the viewing room. Four said that they did not see movement. One said that there was slight movement. The other said there was more aggressive movement. I give them weight, too. I just don't know at what point in time that was during the—from 6:42 when the blinds were lowered to 7:06 when death was pronounced, those execution chamber witnesses reported what I just mentioned, but yet there were no lay witnesses anymore. So I think that there is a loss of transparency there that is frankly disturbing. I would give them weight just like I would give the others weight, to answer your question.

Q. Okay. So you're differentiating the people within the execution chamber from lay witnesses, you called them. Is that what you're saying?

A. That's right.

Q. And do you think the people within the chamber would have more weight and credibility than the lay witnesses? Is that what you're saying?

* * * *

[REDIRECT]

[87] Mr. Lockett's attorney, Mr. Autry, and based on the statements that I read into the record from both the Director Patton and Warden Trammell, do you—are you of the medical opinion that Mr. Lockett was not unconscious at some point after the midazolam was administered?

A. That's correct.

Q. And do you—as a medical professional, do you need to have regular practice placing an IV line to determine, as a forensic pathologist, whether somebody has good veins?

A. I do not have to perform that procedure to make that determination, no. I see these on a daily basis, having performed over 6,000 autopsies and reviewing numerous medical records on a daily basis. I do not need to perform that procedure to make that determination.

Q. Okay. And have you ever opined in previous cases whether somebody was, in fact, conscious based on witness accounts and information that's given to you either by one party or another?

A. Yes, and medical records. As I mentioned, I review voluminous records of decedents on pretty much a daily basis. I have for 20 years. And that includes people who are witnessed to die, people that are unwitnessed, issues of pain and suffering, mechanisms of death. I have reviewed numerous ER reports, paramedic reports, hospital records. And, yes, I make that determination, I give that opinion frequently.

MS. KONRAD: No further questions from me, Your

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[12] MS. GHEZZI: This is the updated and the only change is that 93 is on it.

THE COURT: Okay. I'm going to provisionally admit 1 through 88, plus 93. Eighty-nine through 92 are really too non-specific to be meaningfully addressed summarily as I have done with the rest of them. So 1 through 88 plus 93 are provisionally admitted. Provisionally in the sense that if there is a serious question about authentication, when they are referred to, I will expect defense counsel to raise the issue at that point. You may proceed.

MS. GHEZZI: And, again, we'll call David Autry at this time.

THE COURT: Very well.

DIRECT EXAMINATION

BY MR. BAUMAN:

Q. Mr. Autry, please state your full name for the record.

A. David Autry.

Q. All right, sir. And are you an attorney licensed to practice law in Oklahoma?

A. Yes, sir.

Q. How long has that been the case, sir?

A. Twenty-nine years.

Q. Now, were you involved in the Clayton Lockett case?

A. Yes, sir.

Q. How so?

* * * *

[18] remain there until you're escorted out at the conclusion of the execution.

Q. Okay. So we were at the point where the blinds were closed. Can you take us forward from that point, what happened then?

A. There was a 23-minute delay, like I indicated, before they raised the blinds. The blinds were raised at approximately 6:23 p.m. And I could observe Mr. Lockett on the gurney covered with a sheet. I could observe Warden Trammell, the physician, and probably a couple other DOC personnel. Warden

Trammell began the proceedings by asking Mr. Lockett if he had any last words. He said, no, he did not. And the warden then said words to the effect of let the execution proceed or let the execution begin.

Q. And then what happened next that you observed?

A. Approximately seven minutes passed and the warden signaled or indicated to the doctor to check Mr. Lockett to see whether he was unconscious or not. The doctor indicated that Mr. Lockett was not unconscious. Mr. Lockett audibly stated, at that point, "I'm not." And then approximately three minutes after that passed, the doctor was again checking Mr. Lockett to see whether or not he was unconscious. And at that time, he pronounced Mr. Lockett unconscious.

Q. All right. Then what did you observe after that time?

A. For approximately three minutes after that it appeared [19] that Mr. Lockett was unconscious. He was still on the gurney. His eyes were closed. It did appear for about a three-minute period of time after he was pronounced unconscious that he was unconscious.

Q. Okay. And then what happened?

A. After that approximate three-minute period of time, Mr. Lockett began to strain and writhe against the restraints. He attempted to speak and did speak. He raised his head and shoulders up at least three times and he was attempting to speak. He mumbled, "oh, man" or "man" at one point. And also, according to what I observed, said, "Something is wrong." And during this period of time, he was continually going up against the restraints, sitting up or attempting to sit

up, and raising his head and shoulders. Then he would fall back and his head and shoulders would fall back onto the gurney. And this was repeated two or three times.

Q. Okay. And then what transpired next after that?

A. After that, there was a period of time where Mr. Lockett was still writhing against the restraints. At approximately 6:39 p.m., by my estimate, based on looking at the clock on the wall, the warden directed that the blinds to the execution chamber be lowered.

Q. Okay. And you did mention about the —you have made some pretty specific observations as to time and you mentioned about a clock. How did you know what the times were?

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TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING BEFORE THE HONORABLE STEPHEN P. FRIOT UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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[187] it was a difficult situation.

Q. And you don't remember someone calling you a wimp?

A. Let me see. I'm trying to think. No.

Q. Would your memory have been better closer in time to the execution on the 15th of May?

A. Yes. I mean, you know, as time goes on, you forget things and they aren't as clear.

MS. GHEZZI: No further questions.

THE COURT: Any recross?

MR. STEWART: No, Your Honor.

THE COURT: You may step down. We'll have the plaintiffs' next witness.

MS. GHEZZI: Lis Exon.

LISBETH EXON,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MR. BAICH:

Q. Good afternoon, Ms. Exon.

A. Good afternoon.

Q. Could you state your name and spell it for the record, please.

A. Lisbeth Ann Exon. L-I-S-B-E-T-H, A-N-N, last name E-X-O-N.

Q. And could you tell the Court your occupation.

A. I'm a journalist for OETA Public Television. We're a [188] state agency. We broadcast across the state of Oklahoma.

Q. And how long have you been a journalist?

A. Thirty-five years.

Q. And have you been a journalist in Oklahoma the entire time?

A. No. I worked in other markets in television in Orlando, Florida, and Denver, Colorado, and Houston, Texas.

Q. Have you had any other occupations other than being a journalist?

A. Yes.

Q. Can you tell me what else you did?

A. There was a break in my journalism career before I went back to OETA and I worked in the Tulsa County District Attorney's Office as a victim/witness advocate on major cases and also was involved in preliminary hearings.

Q. And maybe you said this. What is your current position at OETA?

A. I'm a producer journalist reporter.

Q. I would like to direct your attention to April 29, 2014. Do you have any recollection of what you were doing that day?

A. Yes. I was assigned to cover the executions in McAlester of the two inmates and drove over with my photographer and met in the—I guess where the reporters gathered in a separate building across the way from the McAlester state prison.

Q. And am I to understand that the reporters gather in one

* * * *

[192] A. Okay.

Q. You noted that—I'd like to direct your attention to the middle of the page, starting at the top up there, 6:23:35.

A. Yes, from—the first drug was administered at 6:23 and 35 seconds. And from that time to 6 minutes and 28 seconds, so about four and a half minutes, Lockett is just on the gurney with a sheet over him staring at the ceiling. His eyes just keep blinking. And then he's occasionally licking his lips and he's fully conscious.

Q. Could you tell me how you knew what time it was?

A. In the execution room, there is a clock on the back of the wall that we could clearly see.

Q. And you said that a paper and pencil were provided to you. Were you taking notes of your observations?

A. Yes.

Q. Okay. So you noticed that Mr. Lockett was staring at the ceiling, licking his lips. What happened next?

A. At 6:29 he closed his eyes, but he's still breathing. And at 6:30:35, so 6:30 and 35 seconds, the doctor opens Lockett's eyes and kind of thumps on his chest and says something to the warden. And then the warden announced Lockett is not unconscious. And then at 6:32, Lockett's eyes closed and his mouth kind of went slack. It was open. And the doctor approaches him again and opens his eyes, thumps and rubs on his chest, and then he declared that Lockett is unconscious.

[193] Q. And after the doctor declared that Mr. Lockett was unconscious, what did you see next?

A. At 6:34:55 Lockett is still on the gurney breathing. So about a minute and a half later, at 6:36, he kind of lifts up off the gurney. He's strapped down, so he can only move his shoulders and his head forward. And I remember him kind of almost doing a circular—you know, not a whole circular, but just kind of a half moon motion and he mumbles something is wrong.

Q. You indicated that he was rolling. Do you know which way he was trying to roll?

A. He was kind of leaning to the right and just kind of did a half moon and went back.

Q. Did he do this once?

A. No.

Q. Do you know how many times he moved?

A. I'm going to have to look at my notes here. Okay. So then he—again lifting his shoulders off the gurney after he had done it once and then he's lifting up and then he's grimacing, lifting his head and shoulders off the gurney, and then he lifts his upper head and shoulders with a lot more force. It just seemed to get—his jerking up off the gurney seemed to be getting more forceful. And I heard him say, "man." Like, "oh, man," you know, like—and then when he did that—when he did the last gigantic—really large [194] pronouncement jerking forward, shoulders off the gurney, head moving forward, grimacing, then they announced, ladies and gentlemen, we're going to temporarily close the blinds.

Q. You said that the lifts got more progressive.

MR. BAICH: Susie, could you pull up 653, page 653.

Q. (BY MR. BAICH) And starting with, "you know," could you—

A. I said "you know" a lot. He lifts off the gurney and it progressively gets more pronounced. It was like a violent jerk up.

MR. BAICH: Could you scroll down a little more.

Q. (BY MR. BAICH) Do you see the sentence, "I mean, he—he was using all the force he had to lift up"?

A. Okay. Yes. Because he was strapped down, his movements were restricted, but it was like he was using all the force he had to try to lift up and, you know, like, I don't know, against the strap, just trying as hard as he could.

MR. BAICH: One moment, Your Honor.

Q. (BY MR. BAICH) 656. Toward the top, "I mean he was able to say somethings wrong and oh man."

A. Uh-huh.

Q. So you remember him saying both of those things?

A. Uh-huh.

Q. And 655. Starting with Captain Holt saying, Making kind of a movement.

[195] A. Yes. I guess he's asking me because I think I used the word "grimacing" and wanted me to explain that, like he was in pain. And I said—to explain that I meant I explained to the investigator that he was squeezing his eyes tight and tightening his muscles and his mouth as if he were grimacing in pain.

Q. Okay.

MR. BAICH: No further questions.

THE COURT: Cross-examination.

CROSS-EXAMINATION

BY MR. STEWART:

Q. Ms. Exon, you stated that it looked like he was in pain, correct?

A. Uh-huh.

Q. You don't have any medical background, do you?

A. No.

Q. You're not a licensed physician?

A. No.

Q. You're not a licensed EMT?

A. No.

Q. You're not a licensed nurse?

A. No.

Q. So this was merely your lay interpretation of what you were seeing?

A. It is consistent with other people I have seen in great

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[301] and we weren't changing anything but the drug. You know, we had changed the first drug before to pentobarbital from sodium thiopental. And so that's the only part that I was concerned about was the first drug, the sedating drug.

Q. And, in fact, those changes that you made to the protocol as you're talking about it, that was the only substantive change you were making, wasn't it, was the drugs?

A. Yes, it was.

MR. HADDEN: Thank you.

THE COURT: You may step down. We'll have the plaintiffs' next witness.

MR. BAUMAN: Your Honor, we call Scott Crow.

THE COURT: Say that again.

MR. BAUMAN: Scott Crow.

SCOTT CROW,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MR. BAUMAN:

Q. Mr. Crow, would you state your full name for the record, please.

A. Yes, sir. My name is Scott Crow, C-R-O-W.

Q. Okay. And you've previously been deposed in this case as a Rule 30(b)(6) witness representing the Department of Corrections; is that correct?

A. Yes, sir, that's correct.

[302] Q. All right. So in the five years preceding the Lockett execution, how often did the Department of Corrections use a one-line IV system—

THE COURT: First of all, I need to know what's his job, who is he?

MR. BAUMAN: All right.

THE COURT: I got his name and he's a 30(b)(6) witness.

MR. BAUMAN: All right. Sorry, Your Honor.

Q. (BY MR. BAUMAN) What do you do at the Department of Corrections?

A. Sir, I'm the administrator of the field operations division.

Q. Okay. And you've not directly been involved in carrying out executions at the Department of Corrections; is that correct? I mean, you were deposed as a representative from the department, correct?

MR. HADDEN: Your Honor, I'm going to object to that on the basis—

COURTROOM DEPUTY: Use the microphone.

MR. HADDEN: I'm sorry. I'm going to object to that on the basis of 1015(B).

THE COURT: That will be sustained. There's another way to skin that cat, but that's not the way.

MR. BAUMAN: Okay.

* * * *

[320] A. Yes, sir, I did have some responsibility with that.

Q. Could you just explain briefly what those responsibilities were.

A. Director Patton requested that I—after the Clayton

Lockett execution that we do an assessment of the overall execution area and determine what could be done to improve on the structure of that process, the equipment and supplies that were—would be available and just improving on the overall efficiency of that area.

Q. Could you describe for the Court—you don't have to give every single detail, but describe generally what the improvements consisted of and what was changed.

A. Yes, sir. For the purpose of clarification, when we refer to the execution chamber, we're basically

referring to four components. We're referring to the witness room; the victim/witness room; the operations room, which was previously referred to as the chemical room; and then the actual execution chamber.

In the witness area, we actually—actually, this impacts a couple different areas, but one of the bigger changes was expanding the size of the operations room by approximately 3-and-a-half feet to accommodate the need for additional equipment and supplies. In doing that, we reduced the size of the actual execution chamber by the same number, which was approximately 3-and-a-half feet. And in doing that, it [321] decreased the size of the viewing windows from the witness room into the chamber, again, by approximately 3-and-a-half feet, which resulted in the number of chairs that were in the witness area previously being 25, that number was reduced to 19.

The doorway that was previously—that led from the witness area into the actual execution chamber, then ultimately into the operations room, that doorway was relocated out onto the hallway on the upper level of H-Unit. That change was made in order to improve on ingress and egress as far as into and out of the chamber in the operations room.

With regard to the witness area, we installed a drop ceiling. We improved the speaker system in that area as well as the sprinkler heads that were on the fire suppression system and also the ventilation system. We carpeted the whole area as well as replaced the previous fold-up style chairs with permanent chairs that are now affixed to the floor for security reasons.

We enhanced the glass that allows for viewing from the witness area into the actual execution chamber. We enhanced that with Lexan, which is bonded with—

it's five-eighths Lexan, which is bonded with glass, again for security reasons.

In the victim/witness area, we replaced the previous glass that was just regular glass that had privacy film placed on it to help with confidentiality of those witnesses, we replaced that with actually two-way privacy glass. We expanded the foot [322] room in that area by approximately 6 inches to allow for better entry—or egress and ingress as well as improve the ventilation system in that area and also replaced the chairs and installed a small light to ensure—or to improve on the safety of that area.

In entering the operations room, that area again was expanded by approximately 3-and-a-half feet. That area we installed a video system which consists of two monitors that provided video—or that allow for video feed from the execution room which has two cameras installed. One of the cameras is at the head of the bed.

THE COURT: I'm going to ask you to slow down, please.

THE WITNESS: Yes, sir. I apologize. One of the cameras is at the head of the bed. The other camera is at the foot of the bed. Each of those cameras have pan-tilt-zoom capability. So we have a controller in the operations room that allows for those cameras to be adjusted fixed at different locations as far as someone on the bed. We—yes, sir.

Q. (BY MR. HADDEN) Can I stop you right there because I wanted to make a point about the video feed. Is it your understanding on the new protocol that the members of the IV Team will remain in the control room during the execution unless needed in the execution chamber?

A. Yes, sir, in the operations room.

[323] Q. Okay. Will the IV Team members have access to this video feed during the execution?

A. Yes, sir. It is right there. It is on monitors that are—19-inch monitors that are displayed right there.

Q. And is it one of the intents with this upgrade to the video system that it provide a direct observation of the point of IV access so it can be monitored throughout?

A. Yes, sir, that's correct.

Q. And, again, that would be monitored by an IV Team member, correct?

A. Yes, sir.

Q. And pursuant to your understanding of the protocol, an IV Team member has to have at least some level of medical qualification, correct?

A. That's my understanding, sir.

THE COURT: Do both cameras have the tilt and swing capability?

THE WITNESS: Yes, sir, they do.

Q. (BY MR. HADDEN) Okay. Please continue.

A. With the camera systems, again, they provide the video feed into the operations room. The cameras and the video feed for that particular system are not recorded. They are not set up to record. They do not have the capability to record the way that they are installed.

In addition to that, we also replaced the sound system [324] throughout the execution chamber. And let me back up, sir, and say that in addition to the

video feed that's provided in the operations room, there is actually a component that allows for the video feed to be provided to the overflow area for the victim/witnesses which is located on the first floor of H-Unit. So we actually have that ability as well. We have the ability to turn that on and turn that off.

THE COURT: Let me interrupt with one clarifying question. You mentioned that the—there are basically four components to the physical arrangement. You referred to the victim and witness rooms. Am I to understand that there is one room that is for victim/witnesses or victim family witnesses only and then another room that more generally is for other individuals who are authorized to view the execution?

THE WITNESS: Sir, the victim/witness, we actually have a room within the chamber itself that's for victim/witnesses, but we have an area that's designated on the first floor that's actually a programs room that can be used to accommodate an overflow if we have a number of victim/witnesses that exceeds the capacity of the room in the chamber.

THE COURT: I understand that. But you mentioned four components to the execution chamber. Just list those four to me speaking slowly.

THE WITNESS: Yes, sir. It would be the operations room, the execution chamber itself, the witness room, and the [325] victim/witness room.

THE COURT: Okay. That's what I thought. Go ahead. Next question.

Q. (BY MR. HADDEN) Okay. Is there any further upgrades that

A. Just a couple, sir. We improved on the sound system. Again, we created a two-layer system. One

system is that, as I mentioned previously, where the mic is turned on and off from the execution chamber into the witness area. The second mic, which I referred to as the lapel mic, is actually a mic that's placed on the offender when he is secured—he or she is secured to the bed. At that time, that microphone is turned on and it remains on throughout the process of the execution. But, again, that audio feed is only into the operations room and nowhere else.

In addition, in that particular area, we installed a medical supply—medical equipment and supply cabinet as well as installed seating benches that have storage capabilities within them. In addition to the medical supply cabinet, we created an inventory list of all the medical supplies that are required to be maintained in that area and an inventory list to ensure that they are inventoried and maintained regularly.

Additionally, we installed a phone bank of three phones in the operations room that allows the director direct access to the Governor's Office, the Attorney General's Office, and then [326] a third line that could be utilized as an outside line but it's specifically designated for communication within the facility. Beside that, we installed a two-way microphone—or a two-way intercom system. That is a system that allows for communication between the operations room and the execution chamber itself.

With that system, the director or anyone in the operations room can actually communicate into the execution chamber. And the person in that room can actually communicate through a device that's in that room as well or they can just speak through the microphone that's—that protrudes from the wall and

the communication goes back into the operations room.

Further, we installed an ECG machine that has the capability of monitoring the offender's blood pressure, oxygen saturation, and heart activity. In addition to the one machine, we have a second machine that is exactly like the first that serves as a backup should there—we experience a problem with the first machine. We also purchased an ultrasound machine, a portable ultrasound machine for, in our application, artery or vein detection. We replaced the existing surgical table that was in the room that was experiencing problems with the hydraulics.

One of the things that we also completed was a backup to the overall system as far as electrical is concerned. And we installed all the equipment in such a way that it has—it's [327] on battery backup should there be a problem or we experience a problem with utilities there. The equipment has an operational capacity of up to five hours should the electricity fail. We also installed a sink in the operations room, which was not there previous, as well as a small heating and ventilation system that was also not there previously.

Q. Okay. One of the things that you had talked about, I didn't want to just ask you one or two questions about, and that is you talked about expansion of the ops room, I believe. Do you recall talking about that?

A. Yes, sir, I do.

Q. Okay. And was that something that was done as a result of recommendations from the Department of Public Safety?

A. Yes, sir, in a sense. There was—the recommendation was to expand on equipment and supplies. And in order to do that, we had to make for more room in that area to accommodate that equipment and supplies. So, yes, sir, in a sense.

Q. In terms of reduction of chairs, I think you said they went from 25 to 19; is that correct?

A. Yes, sir, that's correct.

Q. Okay. Are there a number of persons who are required to have seats available pursuant to Oklahoma law?

A. Yes, sir, there are.

Q. And just briefly, you don't have to give me every one, but just briefly, what types of persons are required to have seats?

[328] A. Sir, I'm not prepared to specifically state which individuals are and are not, but it's my understanding that, of course, witnesses—as far as the offender witnesses and family is concerned, there's accommodations for those individuals as well as law enforcement from the county or jurisdiction from which the crime occurred, whether that be the district attorney or the sheriff. And to the best of my ability to quote, sir, that's what I can speak to today.

Q. Okay. That's fine. But it is your understanding that there is a state law that governs at least—or mandates the use of some of those seats?

A. Yes, sir.

Q. You also mentioned an ultrasound machine. What is the purpose of that specific machine?

A. In our application, sir, it is a—if you will, a vein detector or an artery detection device.

Q. Okay. And was that—was that purchased or placed in there as a result of DPS recommendations?

A. Yes, sir, I believe that's correct.

Q. If a medical professional who was going to be involved in an execution wanted additional equipment, is there anything in the protocol to your knowledge that would prohibit them from bringing it or requesting it?

A. Not to my knowledge, sir.

Q. You also mentioned replacement of the table. Do you

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[607] Q. And you don't know whether anyone at DOC has?

A. I do not have that knowledge. I can tell you I have not contacted OU Medical. I believe that's who you said.

MS. GHEZZI: That's all. It was more than one question.

THE COURT: Very well. Any cross-examination?

MR. JOSEPH: No, Your Honor. Thank you.

THE COURT: You may step down.

THE WITNESS: Thank you, Your Honor.

THE COURT: Now, I take it that concludes the plaintiffs' presentation of testimony?

MS. GHEZZI: It does, Your Honor.

THE COURT: Very well. We'll have the defendants' first witness. Actually, be the second witness.

MR. HADDEN: Defendants call Dr. Joni McClain.

JONI McCLAIN,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MR. HADDEN:

Q. Good afternoon. Will you please state your name and spell it for the record.

A. Joni McClain. That's J-O-N-I, M-C, capital C, L-A-I-N.

[608] Q. And would you please just briefly go over your—well, let me start first: Did you have some involvement in the investigation of the execution of Offender Clayton Lockett?

A. Yes, I did.

Q. And what was that?

A. I performed the autopsy in Dallas at the Southwestern Institute of Forensic Sciences. The autopsy was ordered by Governor Mary Fallin.

Q. Would you briefly review your qualifications to perform that autopsy.

A. Graduated from the University of Oklahoma School of Medicine in 1983. I then spent four years at the Oklahoma Teaching Hospital doing an anatomic and clinical pathology residency. After that, I spent one year at Indiana University doing a forensic pathology fellowship. After that, I spent four years in the Air Force as a medical examiner at the Office of the Armed Forces Medical Examiner. Then I was hired in Dallas in June of 1992 as a medical examiner and I became the deputy chief in October 2004.

I'm board certified in anatomic, clinical and forensic pathology. And I'm also the past president of the National Association of Medical Examiners. I'm licensed to practice medicine in Texas and Oklahoma.

Q. Okay. Thank you. And are you currently employed at SWIFS?

[609] A. I'm now retired. I retired June of this year.

Q. Thank you. Doctor, as part of your examination, at some point you received the body of Clayton Lockett, correct?

A. Correct.

Q. Are you critical of anything that was done or not done to the body of Clayton Lockett before you received it?

A. No.

THE COURT: That covers a lot of ground.

MR. HADDEN: I thought I would see how that went, Your Honor.

THE COURT: Well, I mean, this started on the 29th of April.

MR. HADDEN: All right, Your Honor. Trying to move it along.

Q. (BY MR. HADDEN) Is there anything that was done or not done to the body of Clayton Lockett before you received it that in any way interfered with your ability to examine it?

A. Really, nothing interfered. I received everything from the Tulsa Medical Examiner's Office. They had started an autopsy where they had made a superficial incision and they had also removed veins and had pinned them out and sent them to our office in formalin. They did a good dissection on that.

Q. Okay. Doctor, I'm going to ask you to refer to your report, which is marked as Plaintiffs' 66 and 67, and ask if

* * * *

[622] concentration of that substance in the blood that was drawn?

THE WITNESS: It shouldn't. You know, the body was refrigerated. And I believe if you have it, I think Oklahoma may have run that also in their tox lab, and I don't know what their level was. I could probably look through here. I may have that or you may have it, but we could look at that.

Q. (BY MS. KONRAD) And that was going to be my next question, to ask you about that. Have you seen the Department of Public Safety executive summary that was done of their investigation of Clayton Lockett?

A. You'll have to show me what that looks like.

MS. KONRAD: Can you pull up Exhibit 65, please.

Q. (BY MS. KONRAD) And it's on the screen in front of you, Dr. McClain.

A. I may have seen this. I can't be for sure, but if you've got the tox from Oklahoma, let's see what that is.

Q. The—in this executive summary, it has a summary of the tox on page 19. And at Section E, they summarize the toxicology results from OCME. And they have there at the third sentence I think it says the results indicated midazolam concentration of .57 micrograms per milliliter. Do you see that?

A. Yes.

Q. And would that information change your opinion that he had [623] been administered midazolam above therapeutic levels?

A. Look real quick. It's micrograms per mill. It's probably more—kind of looking at it, then these other units, it's therapeutic to a little over.

Q. And what do you mean by a little over therapeutic?

A. There is some examples here. This is from Baselt, a 5 milligram IV dose, the average is 112 micrograms per liter.

Q. And just so I understand what you're reading from, that data, is that in a deceased person?

A. Yes, that's—Baselt is a toxicology book that medical examiners use.

So in this one, micrograms per liter and this was micrograms per milliliter, and so that would be, like, 570 that would convert to micrograms per liter. So a 5 milligram dose, you would get, like, 112, and this would be the same as 570 micrograms per liter.

And then to maintain, you know, surgery, that's 1,254 micrograms per liter. So you usually need more than that or the average that they give to someone that's undergoing surgery. This is about a half of the amount that you would normally get to maintain surgery.

The units are all different, so you have to kind of convert.

Q. Did you do any calculations to support your autopsy report?

OKLAHOMA DEPARTMENT OF PUBLIC SAFETY

The Execution of Clayton D. Lockett

Case Number 14-0189SI

Executive Summary

Table of Contents

I. BACKGROUND 1
II. INVESTIGATION 2
A. Autopsy of Clayton D. Lockett 3
B. Tour of the Oklahoma State Penitentiary 3
C. Collection of Evidence 5
D. Review of Surveillance and Camcorder Video 5
E. Documentation Provided by Oklahoma Department of Corrections 6
F. Interviews 7
III. FINDINGS 8
A. Timeline 8
B. Autopsy Results for Clayton D. Lockett 13
C. DOC Execution Protocols 14
D. IV Insertion, Viability and Administration of Execution Drugs 14
E. Toxicology Results of Femoral Blood Sample: Clayton D. Lockett 19
F. Toxicology Results of Execution Supplies: Clayton D. Lockett 19
G. Toxicology Results of Execution Drugs: Charles Warner 20

H. Execution Protocol Training of Execution Team 20
I. Contingency Planning for Executions 22
J. Cessation of Execution Protocols 22
K. Two Executions Scheduled on the Same Day 23
L. Maintenance of Daily Logs 23
M. Use of Midazolam, Vecuronium Bromide and Potassium Chloride 24
N. Historical Incident Reports and Medical Records 24
O. Lockett's Movements and Sounds after Drug Administration 25
IV. RECOMMENDATIONS 26
A. Observation of IV Insertion Point(s) and Infusion 26
B. Training and Maintenance of Execution Log for Condemned Offenders 26
C. Additional Execution Supplies 27
D. Contingency Plans in Protocols/Policy 27
E. Formal and Continuing Training Program for Execution Personnel 28
F. Formal After-Action Review of the Execution Processes 28
G. Defined Execution Terminology 28
H. Completion of One Execution per Seven Calendar Days 28
I. Updated Methods of Communication 28
J. Disposition of Executed Offender's Property. 29
K. Execution Witness Briefing 29

I. BACKGROUND

The State of Oklahoma, through the Office of the Attorney General (OAG), filed an *Application for Execution Date* for Clayton Derrell Lockett on January 13, 2014. Lockett had been convicted of first degree murder for a 1999 case in Noble County and sentenced to death. On January 22, the Oklahoma Court of Criminal Appeals ordered the execution to be set for March 20. Motions were later filed on behalf of Lockett and another offender sentenced to death, Charles Warner, that challenged Oklahoma's execution-secrecy law and execution protocol. On March 18, the Court of Criminal Appeals vacated Lockett's execution date and it was reset for April 22. This order also rescheduled Warner's execution from March 27 to April 29.

On April 9, the Court of Criminal Appeals denied an application for stay made by both offenders. On April 21, the Oklahoma Supreme Court issued a stay of execution for Lockett and Warner. In response, Governor Mary Fallin issued Executive Order 2014-08, which granted a stay of Lockett's execution and rescheduled it for April 29, based on the Supreme Court not having constitutional authority to issue a stay. On April 23, the Supreme Court dissolved their stay. Between April 23 and April 29, an application for extraordinary relief was denied by the courts, as was another request for a stay.

On the morning of April 29, Oklahoma Department of Corrections (DOC) personnel began procedures to prepare for Lockett's and Warner's executions at the Oklahoma State Penitentiary (OSP) in McAlester, Oklahoma. Lockett's execution was scheduled to begin at 6:00 p.m. Lockett was removed from his cell that morning and taken to the Institutional Health Care

Center (IHCC), located on prison grounds, for self-inflicted lacerations to the inside of his arms and his pre-execution medical examination. Lockett remained at IHCC until later that afternoon, when he was returned to H-Unit to await his execution.

Lockett was taken to the execution chamber, placed onto the table, and after failed attempts in other locations, an intravenous (IV) line was started in Lockett's right groin area. On the order of Warden Anita Trammell, the administration of execution drugs began. Several minutes into the process, it was determined there was a problem with the IV patency. The execution was stopped and Lockett later died in the execution chamber.

On April 30, Governor Fallin issued Executive Order 2014-11, which appointed Secretary of Safety and Security and Department of Public Safety (DPS) Commissioner Michael Thompson to conduct an independent review of the events leading up to and during Lockett's execution. This order stated the review should include:

1. An inquiry into the cause of death by a forensic pathologist;

2. An inquiry into whether DOC correctly followed their current protocol for executions;

3. Recommendations to improve the execution protocol used by DOC. The order further directed that the Office of the Chief Medical Examiner (OCME) authorize the Southwestern Institute of Forensics Science (SWIFS) in Dallas, Texas to perform the autopsy, additional examination, and all other related testing of Lockett's remains.

In order to effectuate the examination, OCME was directed to transport Lockett's remains to and from SWIFS. OCME was also ordered to appropriately maintain Lockett's remains until they were released to his family. Commissioner Thompson assembled a team of DPS investigators to conduct this investigation and report its findings. This executive summary, along with its attachments and supporting documentation, are the result of the investigation conducted by this team.

II. INVESTIGATION

This investigation was conducted by a team of six investigators assigned full-time to the case. Nine investigators and a criminal intelligence analyst were also utilized part-time to assist with the case. All investigators were sworn, law enforcement members of the Oklahoma Highway Patrol (OHP) Division of DPS. A medical expert was also consulted during the investigation to assist the investigators in understanding the various technical aspects related to the medical procedures that were performed during the execution. The expert was a current, American Board of Surgery certified physician with more than 35 years of experience in the medical field. The remainder of this section outlines the methodology utilized by the team to complete this investigation.

A. Autopsy of Clayton D. Lockett

On April 29, at 7:50 p.m., DOC released Lockett's body to the OCME designated transport contractor, Ray Francisco's Embalming Service, who transported the body to OCME in Tulsa, Oklahoma. On the morning of April 30, OCME pathologists began an external examination of the body. A portion of the superficial veins of the right and left arms were

explored, photographed and removed. Personnel also obtained a blood sample from the left femoral artery/vein. Around 11:30 a.m., pathologists were notified to stop the examination pursuant to the aforementioned Executive Order. They had not started a posterior body inspection or internal examination. OCME staff sealed the body and evidence in a body bag and placed it in storage. Later that day, Lockett's body and evidence were transported by Ray Francisco's Embalming Service to SWIFS and the transport was monitored by a member of the investigation team.

On May 1, the autopsy of Lockett's body was conducted by Dr. Joni McClain and other SWIFS staff. A member of the investigation team observed the autopsy and evidence processing procedures. Dr. McClain completed the external and internal examinations of the body utilizing SWIFS' normal procedures and protocols. After the autopsy was complete, Lockett's body was released to Ray Francisco's Embalming Service and transported back to OCME in Tulsa.

During this investigation, the investigation team met with the SWIFS pathologists and staff to gain a better understanding of their autopsy process and its findings. The results of the autopsy and the toxicology tests that were completed are summarized in the *Findings* section of this report.

B. Tour of the Oklahoma State Penitentiary

On May 5, the investigation team met with Warden Trammell and several OSP staff members to prepare for a tour of H-Unit and IHCC. The team was escorted through H-Unit, where they viewed the holding cells, shower, execution chamber, executioners' room and medical room. The team also collected evidence during

the tour. The team was then escorted to IHCC and viewed the area where Lockett was treated for his self-inflicted wounds and the cell where he was held, until being returned to H-Unit. After the tour, the team met with Warden Trammell and her staff to collect additional evidence and retrieve documents requested for the investigation. Several measurements and photographs were taken during the tour to document the execution facilities, which were later used to construct Diagram II.1.

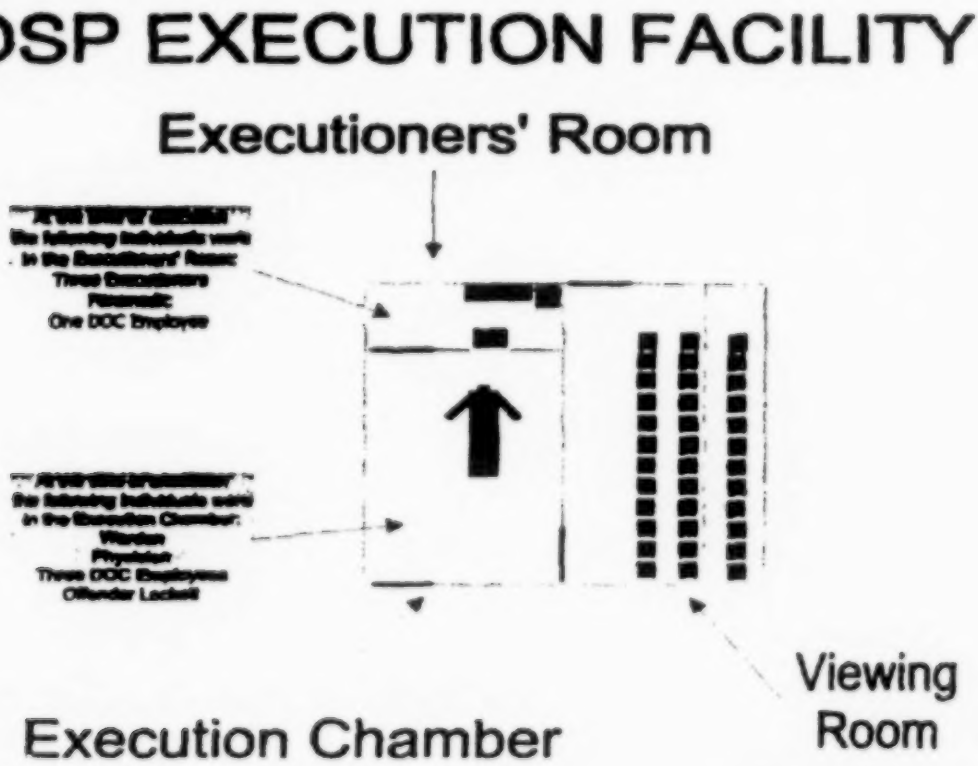

Diagram II.1

On June 30, members of the investigation team returned to OSP to gather additional information from the execution chamber. A team member was strapped to the execution table by two OSP strap-down team members who had strapped Lockett to the table. OSP staff observed the process to ensure that every strap

was utilized in the same manner it was on the day of Lockett's execution. The team measured the ability for a person to move and their range of motion, once secured to the table, and took photographs from the viewing room to show the different perspectives from the various seating locations.

C. Collection of Evidence

Numerous items of evidence were collected and preserved during this investigation. This evidence included digital photographs, audio recordings, video recordings, documents and other items of physical evidence. The remainder of this section is a summary of the evidence collected.

During their examination, OCME staff collected a blood sample from Lockett's left femoral artery/vein. An aliquot of that sample was submitted by OCME to NMS Labs in Willow Grove, Pennsylvania, to test for the presence and concentration of midazolam and vecuronium bromide. On June 12, the investigation team obtained another aliquot of that sample and submitted it to ExperTox Laboratory in Deer Park, Texas, to test for the presence and concentration of potassium. In accordance with their normal procedure, OCME had not requested NMS Labs to test for the presence and concentration of potassium. The results of these examinations are included in the *Findings* section of this summary. The remainder of the sample is being stored by OCME.

On May 1, evidentiary items related to the administration of execution drugs to Lockett were released by SWIFS to the investigation team. These items were delivered by a team member to ExperTox. Evidence items that were inside Lockett's body bag and body are being maintained at SWIFS, the

Oklahoma State Bureau of Investigation Laboratory or the OHP evidence storage facility. The team also collected the execution drugs and containers that were prescribed to offender Charles Warner. Custody was transferred from OSP personnel to a team member, who hand-delivered them to ExperTox for testing.

On May 5, approximately 200 items of evidence were collected at OSP, during the facility tour. They consisted of items from Lockett's cell, the execution chamber, the executioners' room and video footage from inside the facility prior to the execution. Executions are not recorded; therefore, there was no video footage of the actual execution. These items are being maintained at the OHP evidence storage facility.

D. Review of Surveillance and Camcorder Video

Thirty-two compact disks containing surveillance and camcorder video footage were collected and viewed. Following is a summary of this video provided by DOC:

1. Video surveillance footage from OSP for April 29, from 5:15 a.m. to 5:22 p.m., that recorded Lockett's movements in H-Unit and IHCC;

2. Camcorder video footage for the planned use of force that showed the extraction of Lockett from his cell on the morning of April 29. The footage contained statements explaining the force, restraints to be used and each extraction team member's duties. The footage also captured his treatment at H-Unit medical, his transport to IHCC, his treatment at IHCC and his X-ray;

3. Camcorder video footage of Lockett refusing a meal on April 29. The footage captured Lockett

refusing a meal and had a statement from DOC personnel that Lockett had refused all three meals that day.

E. Documentation Provided by Oklahoma Department of Corrections

Throughout this investigation, several hundred pages of documents were requested and obtained from DOC. This team requested any documentation related to Lockett and his execution, including but not limited to logs, incident reports, timelines and historical medical records. Following is a non-inclusive summary of those documents obtained from DOC.

1. Memorandums from Warden Trammel to OSP personnel;
2. Legal documentation related to Lockett's court proceedings;
3. Use-of-force documentation from April 29, including TASER training records;
4. Property inventory and log of items sent to Lockett's family;
5. Sequence of events, execution logs and execution timeline;
6. Lockett's historical medical records, mental health check information and case manager reports;
7. Execution drugs chain-of-custody forms;
8. Execution duties listed by department and training/practice logs;
9. Lockett's 30-day notification packets;
10. DOC execution procedures;

11. Various incident reports;
12. Affidavit of Warden Anita Trammell related to the execution drugs;
13. Diagram of the execution chamber;
14. Death warrant for Clayton Lockett;
15. Execution debrief personnel log;
16. Execution chamber key log;
17. Interoffice memorandums, emails and training documents related to the execution duties of DOC personnel.

F. Interviews

During this investigation, 113 people were identified to interview. Of those, 108 were interviewed, four media witnesses who viewed the execution declined to interview and one OCME employee was on extended leave and not available to interview. Follow-up interviews of select witnesses were also conducted. Each interview, with the exception of four, was audio recorded and reduced to a typed report by a transcription service. The four interviews that were not recorded included the three executioners and the pharmacist. Below is a summary of those that were interviewed:

1. The physician, Warden Trammell and three additional DOC personnel that were in the execution chamber at the time of the execution;
2. The paramedic, one DOC employee and the three executioners that were in the executioners' room at the time of the execution;

3. Persons that viewed the execution from the viewing room or overflow area, including personnel from DOC, Office of the Attorney General, media outlets, Lockett's attorneys, members of the Neiman family, the Noble County District Attorney and Sheriff's offices, the Perry Police Department and the Secretary of Safety and Security;

4. Governor Fallin and eight members of her staff;

5. Members of DOC's administrative staff including the Director, Associate Director, District Manager, current and former members of DOC's General Counsel staff;

6. OSP corrections officers involved in different aspects of the execution, including staff who interacted with Lockett several days leading up to the execution;

7. DOC medical and mental health staff members;

8. OCME staff involved in the examination and chain-of-custody of Lockett's body and evidence;

9. Employees of Ray Francisco's Embalming Service responsible for the transport of Lockett's body;

10. The pharmacist that filled the prescription of execution drugs.

III. FINDINGS

After reviewing and considering all interviews, documentation and evidence gathered during this investigation, this team has reached several conclusions regarding Lockett's execution. Some factors ultimately contributed to the issues that arose during the process, while others directly affected how those issues were handled by the personnel in the execution chamber. Each of this team's findings is listed below, along with a detailed timeline of events.

A. Timeline

The following is a timeline of events that occurred in regards to Lockett's execution. The approximate times associated with each event have been compiled utilizing witness accounts and documentation obtained during this investigation.

April 29, 2014

12:00-4:30 a.m.	DOC personnel conducted a unit check and count in H-Unit every 30 minutes. At 12:30 a.m., personnel conducted a welfare check of Lockett and no problems were noted or discovered.
4:30-5:05 a.m.	The Correctional Emergency Response Team (CERT) arrived at H-Unit and began preparations to remove Lockett from cell SW-3-JJ to escort him to IHCC for x-rays.
5:06 a.m.	CERT arrived at cell SW-3-JJ and Lockett refused to comply with orders. He was covered by a blanket and moving, but would not uncover

	or approach the cell door to be restrained.
5:09-5:50 a.m.	CERT exited the area of cell SW-3-JJ to prepare for cell entry and extraction. Blood was observed by DOC personnel inside cell SW-3-JJ. A use of force plan was established and approval was given by DOC administration to utilize a TASER.
5:30 a.m.	DOC personnel performed another check and Lockett failed to comply with the order to approach the cell door and uncover himself.
5:50 a.m.	CERT arrived at cell SW-3-JJ for extraction and determined Lockett had attempted to jam the door. The door was forced open, Lockett refused to comply with verbal commands and a TASER was deployed. CERT members observed self-inflicted lacerations on Lockett's arms.
5:53 a.m.	Lockett was secured by CERT, removed from the cell, placed on a gurney and transported to H-Unit medical. A razor blade from an issued, disposable shaving razor was located inside the cell and confiscated.
5:53-6:45 a.m.	Lockett was medically evaluated at H-Unit medical.
6:35 a.m.	Lockett was transported from H-Unit medical to IHCC. He was

	placed in IHCC holding cell S2 and remained in handcuffs and leg irons.
6:45 a.m.	DOC personnel entered cell S2 and medical staff evaluated Lockett's lacerations.
7:00-8:15 a.m.	DOC personnel entered cell S2 every 15 minutes to check Lockett.
8:15 a.m.	Lockett was removed from cell S2 and taken to the IHCC emergency room to be examined by DOC medical staff.
8:40 a.m.	Lockett was returned to cell S2.
8:50-9:35 a.m.	DOC personnel entered cell S2 every 10-15 minutes to check Lockett.
9:15 a.m.	Lockett refused visits from his attorneys.
9:42 a.m.	Lockett refused a food tray.
9:55 a.m.	DOC personnel entered cell S2 to check Lockett.
10:15-10:30 a.m.	DOC personnel entered cell S2 to check Lockett every 15 minutes.
10:25 a.m.	Lockett confirmed his refusal to visit with his attorneys.
10:45 a.m.	DOC personnel entered cell S2 to check Lockett and adjust restraints.
11:11 a.m.	Lockett refused a food tray.

11:20 a.m.	DOC personnel entered cell S2 to check Lockett and adjusted restraints.
11:35 a.m. - 3:55 p.m.	DOC personnel entered cell S2 to check Lockett every 15-20 minutes.
3:35 p.m.	DOC personnel retrieved the execution drugs from refrigerated storage at OSP for transport to the execution chamber.
4:10 p.m.	DOC personnel entered cell S2 to adjust restraints, redress and prepare Lockett for transport from IHCC to H-Unit.
4:15 p.m.	DOC personnel placed the execution drugs in the executioners' room.
4:31 p.m.	The three executioners and paramedic entered the executioners' room and began preparation.
4:40 p.m.	Lockett was transported to H-Unit and placed into shower SW-4.
4:55-5:10 p.m.	Lockett visited with a DOC mental health staff member.
5:19 p.m.	The five strap-down team members and Warden Trammell entered the cell area to remove Lockett from shower SW-4.
5:21 p.m.	Lockett was removed from shower SW-4 and escorted to the execution chamber.
5:22 p.m.	Lockett was placed onto the execution table and strapped down.

5:26 p.m.	The strap-down team exited the execution chamber.
5:27-6:18 p.m.	The paramedic and physician attempted IV placement access in multiple locations and were unsuccessful. The physician believed he started an IV in Lockett's right groin area.
5:45-5:57 p.m.	Victim's witnesses, media personnel, and Lockett's attorneys were summoned to the viewing room and seated.
6:18 p.m.	The paramedic and physician determined the IV line was viable.
6:20 p.m.	The paramedic re-entered the executioners' room.
6:22 p.m.	DOC Director Robert Patton and selected officials were summoned and seated in the viewing room.
6:23 p.m.	Director Patton received approval from the Governor's Office to proceed with the execution. He then approved Warden Trammell to proceed. The blinds between the viewing room and execution chamber were raised and Lockett was asked if he wished to make a statement. He refused and Warden Trammell announced that the execution was to begin. The full dose of midazolam and an appropriate saline flush were administered. A DOC employee began to keep time on a stopwatch.

6:30 p.m.	The signal was given that five minutes had elapsed and the physician determined Lockett was conscious. DOC personnel began to keep additional time on a stopwatch.
6:33 p.m.	The signal was given that two minutes had elapsed and the physician determined Lockett was unconscious. Warden Trammel signaled for the execution to continue. The full dose of vecuronium bromide, an appropriate saline flush and a majority of the potassium chloride were administered.
6:33-6:42 p.m.	Lockett began to move and make sounds on the execution table. It should be noted that the interview statements of the witnesses regarding Lockett's movements and sounds were inconsistent. The physician inspected the IV insertion site and determined there was an issue, which was relayed to Warden Trammell.
6:42 p.m.	At the direction of Warden Trammell, the blinds were lowered. The executioner stopped administering the potassium chloride.
6:42-7:06 p.m.	It should be noted that the interview statements of the individuals in the execution chamber were inconsistent. However, it was determined the following events did occur inside

the execution chamber during this time period.

- The paramedic re-entered the execution chamber to assist the physician.
- The physician attempted IV access into Lockett's left, femoral vein. However, no access was completed.
- When questioned by Warden Trammell, the physician initially believed that Lockett may not have received enough of the execution drugs to induce death. He also believed there were not enough execution drugs left to continue the execution.
- The physician and paramedic continued to monitor Lockett's heart rate utilizing an EKG machine. While attempting to gain the IV access, it was observed that Lockett's heart rate continued to decrease.
- The physician made the observation that the drugs appeared to be absorbing into Lockett's tissue.
- The physician and paramedic concluded that

Lockett's heart rate had entered a state of bradycardia and eventually slowed to an observed six beats per minute.

- There were three different recollections of Lockett's movements during this period. Four reported that Lockett did not move, one reported he moved slightly and the last recalled a more aggressive movement.

The following events occurred outside the viewing room door in the H-Unit hallway.

- Director Patton, OAG representatives Tom Bates and John Hadden and Secretary Thompson removed themselves from the viewing room and discussed with the Governor's Office about how to proceed.

6:56 p.m.	Director Patton halted/stopped the execution, which was relayed to the execution chamber.
6:57-7:06 p.m.	Witnesses were escorted out of the viewing room.
7:06 p.m.	The physician pronounced Lockett deceased.

7:50 p.m. — After being unstrapped from the execution table, Lockett's body was removed from OSP and transferred to the Office of the Chief Medical Examiner transport.

B. Autopsy Results for Clayton D. Lockett

Based on the autopsy, Lockett's cause of death was listed as *Judicial Execution by Lethal Injection*. The manner of death was listed as *Judicially Ordered Execution*. SWIFS pathologists concluded that Lockett died as the result of judicial execution by lethal injection. Following is a summary of the findings made by SWIFS personnel during their examination of Lockett's body and additional information obtained by the investigation team from SWIFS or through the investigation:

1. Judicial execution with:
   a. Execution protocol medications used: midazolam, vecuronium and potassium chloride.
   b. History of difficulty finding intravenous access sites resulting in numerous attempts to start an IV.
   c. Attempts in both antecubital fossa, both inguinal regions, left subclavian region, right foot and right jugular region.
2. Superficial incised wounds of the upper extremities consistent with history of self-inflicted incised wounds with a safety razor.
3. Contusions and abrasions of extremities.
4. Cardiac hypertrophy (480 grams)
5. Mild coronary artery atherosclerosis.

6. Hydroxyzine detected.

a. Lockett was prescribed hydroxyzine, but the prescription had ended March 3. There were emails from DOC personnel alleging Lockett had been hoarding medication. SWIFS personnel stated there were higher than therapeutic levels of hydroxyzine present in Lockett's system and hydroxyzine should not have interfered with the execution drugs administered. They also could not determine when or how much of the hydroxyzine was taken.

7. No evidence of dehydration.

8. No Taser marks on the body.

9. Toxicology indicated elevated concentrations of midazolam in the tissue near the insertion site in the right groin area, which is indicative of it not being administered into the vein as prescribed in execution protocols. The presence of midazolam in the psoas muscle indicates midazolam was distributed throughout Lockett's body during the execution. According to SWIFS pathologists, the concentration of midazolam located in Lockett's blood was greater than the therapeutic level necessary to render an average person unconscious.

10. Vecuronium bromide was found in the femoral blood sample taken from Lockett's body. The presence of vecuronium bromide in the psoas muscle indicates vecuronium bromide was distributed throughout Lockett's body during the execution.

11. Potassium was found in the femoral blood sample taken from Lockett's body.

C. DOC Execution Protocols

Regarding whether DOC correctly followed their current execution protocols, it was determined there were minor deviations from specific requirements outlined in the protocol in effect on April 29. Despite those deviations, it was determined the protocol was substantially and correctly complied with throughout the entire process. None of the identified deviations contributed to the complications encountered during this execution.

D. IV Insertion, Viability and Administration of Execution Drugs

The physician and paramedic made several attempts to start a viable IV access point. They both believed the IV access was the major issue with this execution. This investigation concluded the viability of the IV access point was the single greatest factor that contributed to the difficulty in administering the execution drugs.

While exploring this issue, several DOC personnel made statements referencing Lockett purposefully dehydrating himself. Lockett made statements to the paramedic that he had been dehydrating himself for three days. However, SWIFS pathologists found no indication that Lockett was dehydrated at the time of his execution. SWIFS also concluded Lockett's blood loss from the self-inflicted wounds to his arms should not have caused issues with the IV access.

Interviews and documentation indicated several vein checks had been performed by DOC medical personnel leading up to and on the day of the execution. Each check indicated that Lockett's veins were "good". At least three interviews of DOC medical personnel indicated they viewed Lockett's veins on the

morning of the execution. Their observations concluded his veins were "good" and acceptable for IV access.

The IV insertion process was started by an emergency medical technician licensed as a paramedic. The paramedic had been licensed in emergency medical services for more than 40 years and as a paramedic for over 20 years. This person had also instructed at the intermediate level. The licenses possessed at the time of the execution were valid until 2015 and were from the Oklahoma State Department of Health and the National Registry of Emergency Medical Technicians. The paramedic provided the prison a copy of the above licenses in January or February 2014. The paramedic estimated he/she had been involved in every lethal injection execution in Oklahoma, except for two. His/her specific assignments were to start an IV, ensure a proper infusion of saline, attach a cardiac monitor to Lockett and during the execution, make sure the executioners did their part of the procedure aseptically, at the correct time and the correct speed.

The IV access was completed by a physician licensed as a medical doctor. The physician graduated medical school over 15 years ago, currently worked in emergency medicine and was certified in family medicine. His license expires July 1 of each year and was current at the time of the execution. He had not provided a current copy of his license to DOC prior to April 29, but days later was called and asked for a copy. This was his second execution with the first being four to five years earlier. The physician understood his duties were to assess Lockett to determine if he was unconscious and ultimately to pronounce his death. He was contacted two days prior

to the execution date and asked to fill in for another physician that had a scheduling conflict.

Before Lockett was moved into the chamber, the paramedic prepared the IV lines and available execution tools. He/she also verified the drugs were properly labeled and were for Lockett. After Lockett was brought to the chamber and secured to the execution table, the paramedic began to assess his veins. The paramedic first attempted access in the left arm and found a vein with an 18-gauge needle/ catheter and observed flashback, a condition sought during IV placement. The paramedic did not have adhesive tape on his/her person to secure the catheter. Before the tape was retrieved, the vein became unviable. The paramedic then attempted two additional IV insertions into the left arm using the same type needles/catheters, but never observed flashback.

After these attempts, the physician became involved and attempted IV access into Lockett's left, external jugular vein utilizing a 1¼ inch, 14-gauge needle/ catheter. During his interview, the physician stated he penetrated this vein and obtained flashback. Seconds later, it became unviable and he was unable to continue with that vein. As the physician was attempting this access, the paramedic was attempting IV access into Lockett's right arm. After three attempts, the paramedic was unable to start a viable IV access point in this arm.

Next, the physician attempted to locate the subclavian vein on Lockett's left side utilizing a central venous catheritization kit. During the attempt, the physician observed a very small amount of flashback, but he was unable to repeat it. The physician believed the needle was penetrating through

the vein. He noted during his interview he did not have access to an ultrasound machine, which is a commonly used tool to locate and penetrate veins.

As the physician attempted subclavian access, the paramedic attempted IV access in two separate locations on Lockett's right foot with 20 gauge needles/catheters. The paramedic said the veins rolled and disappeared during those attempts. The paramedic believed the needle penetrated the veins, but flashback was never observed. The paramedic did not attempt access into any other veins because the physician made the decision to attempt access into a femoral vein.

The physician requested a longer needle/catheter for the femoral access. The paramedic attempted to locate a 2 or 2 1/2-inch, 14-gauge needle/catheter, but none were readily available. The physician also asked for an intraosseous infusion needle, but was told the prison did not have those either. Both agreed their preferred needle/catheter length would have been 1¾ to 2½ inches. The physician had never attempted femoral vein access with a 1¼ inch needle/catheter; however, it was the longest DOC had readily available. An additional central venous catheterization kit was available, but the physician did not think about utilizing one for femoral access.

Lockett's scrub pants and underwear were cut in order to expose the femoral area. The physician located the femoral vein and believed the vein was penetrated because he observed good flashback. The paramedic taped the catheter to Lockett's body, and stated during his/her interview it became positional. The physician believed it was bending because of its length. He and the paramedic positioned the catheter where they were able to observe slow infusion of saline

and secured it with adhesive tape. The autopsy did not conclude the femoral vein was punctured. However, SWIFS personnel indicated they only examined the portion of the femoral vein that had been dissected by OCME and not the entire vein.

The physician was asked about starting a second IV line. He stated he was not going to make another attempt. The physician and paramedic were comfortable with the IV placement and the infusion of saline through the line. This was not the first execution in Oklahoma where only one IV access point had been obtained and protocol allowed for only one access point.

Warden Trammell decided to cover Lockett's body with a sheet, including the IV insertion area, which, according to her, was normal in all executions. Another reason for her decision was to maintain Lockett's dignity and keep his genital area covered. From that time, no one had visual observation of the IV insertion point until it was determined there was an issue and the physician raised the sheet. Warden Trammell acknowledged it would be her normal duty to observe an IV insertion point for problems. She believed if the IV insertion point had been viewed, the issue would have been detected earlier. The physician added that an IV would normally be monitored by watching the flow of the IV line and the area around the insertion point for any signs of infiltration. This investigation found that neither of these observations occurred, which led to the issue being discovered several minutes after the execution began.

After the IV insertion was complete, the paramedic went into the executioners' room and the physician remained in the execution chamber. Once Warden Trammell announced it was time to begin the

execution, the paramedic began the procedure to administer the drugs. The paramedic first used a hemostat to clamp the IV line above the access port, to stop the flow of execution drugs from going up the line. The IV drip was never reestablished after that point. The midazolam and the appropriate flushes were administered into the single access port by the executioners in the order they were presented by the paramedic. The paramedic and executioners were certain the drugs were pushed steady and in the proper manner because of their past experiences in performing the same roles. The DOC employee in the executioners' room then began to keep time using a stopwatch.

According to execution protocol, the vecuronium bromide shall not be administered until at least five minutes after the administration of midazolam. Prior to the execution, DOC administration determined if Lockett was not unconscious after five minutes, he would be checked every two minutes, until he was declared unconscious. Five minutes after the administration of midazolam, the physician determined Lockett was conscious. After an additional two minutes, the physician determined that Lockett was unconscious.

Warden Trammell signaled for the execution process to continue. The executioners, with assistance from the paramedic, began administering the vecuronium bromide, the potassium chloride and the appropriate saline flushes. Both syringes of the vecuronium bromide, appropriate saline flushes, the first full syringe of potassium chloride and a portion of the second syringe of potassium chloride were

administered. At some point during the administration of these two drugs, Lockett began to move and the physician recognized there was a problem.

The physician approached Lockett and indicated to Warden Trammell that something was wrong. He looked under the sheet and recognized the IV had infiltrated. At this same time, Warden Trammell viewed what appeared to be a clear liquid and blood on Lockett's skin in the groin area. The physician observed an area of swelling underneath the skin and described it as smaller than a tennis ball, but larger than a golf ball. The physician believed the swelling would have been noticeable if the access point had been viewed during the process.

The execution process was stopped as one of the executioners was administering the second syringe of potassium chloride. The executioner immediately stopped pushing the syringe with approximately 10 milliliters of potassium chloride remaining. The remainder of the drug was later wasted into a biohazard bin by the paramedic.

The blinds to the execution chamber were lowered and the paramedic exited the executioners' room to assist the physician. The physician told the paramedic the catheter dislodged. The paramedic observed the catheter was tilted to one side and believed it was no longer penetrating the vein. The physician decided to attempt IV insertion into the left-side femoral vein. The physician first penetrated Lockett's femoral artery and another access point into the vein was never completed because the physician believed the drugs were being absorbed into his tissue.

The physician and paramedic were unsure when the catheter became dislodged and how much of each drug

had made it into Lockett's vein. The autopsy indicated elevated concentrations of midazolam in the tissue near the insertion site in the right groin area, which was indicative of the drugs not being administered into the vein as intended. Thus, the IV access was not viable as early as the administration of the midazolam.

E. Toxicology Results of Femoral Blood Sample: Clayton D. Lockett

On May 14 and May 19, OCME documented the toxicology results they received from NMS Labs on an aliquot of the femoral blood sample they obtained from Lockett's body on April 30. The results indicated a midazolam concentration of 0.57 mcg/mL and a vecuronium concentration of 320 ng/mL. On June 26, ExperTox completed toxicology testing of an aliquot of the same femoral blood sample. The results of this test indicated a potassium concentration of 0.74 mole/L. It should be noted that testing for the concentration of potassium after death can be problematic due to the body's natural processes, which cause an increase in the concentrations of potassium in the blood over time.

F. Toxicology Results of Execution Supplies: Clayton D. Lockett

On May 5, ExperTox completed testing of the execution supplies utilized during Lockett's execution. They analyzed the contents by liquid chromatography/triple quad mass spectrometry (LC/MSMS) and inductively coupled argon plasma-mass spectrometry (ICP-MS) for the detection and quantitation of midazolam, vecuronium bromide and potassium chloride. ExperTox reported the following:

1. The two syringes labeled midazolam contained residues consistent with the listed label content of 5 mg/mL.
2. The two syringes labeled vecuronium bromide contained residues consistent with the listed label content of 1 mg/mL.
3. The two syringes labeled potassium chloride contained residues consistent with the listed label content of 2 meq/mL.
4. The IV Tubing connected to two 0.9% NaCl one liter IV bags contained sodium chloride, blood, residues of vecuronium bromide at the final concentration of 0.013 g/mL and residues of potassium chloride at the final concentration of 1.3 meq/mL.

G. Toxicology Results of Execution Drugs: Charles Warner

On May 5, ExperTox completed testing of the drugs intended for use during the execution of Charles Warner. They analyzed the contents by LC/MSMS and ICP-MS for the detection and quantitation of midazolam, vecuronium bromide and potassium chloride. These tests were also utilized to determine drug agent potency. ExperTox reported the following:

1. The two 0.9% NaCl injection USP 1 liter IV bags tested consistent with the listed contents.
2. The seven 0.9% NaCl 50 mL bags tested consistent with the listed contents.
3. The two syringes labeled midazolam tested consistent with the listed label content of 5 mg/mL.

4. The two syringes labeled vecuronium bromide tested consistent with the listed label content of 1 mg/mL.

5. The two syringes labeled potassium chloride tested consistent with the listed label content of 2 meq/mL.

H. Execution Protocol Training of Execution Team

This investigation determined that DOC personnel did conduct training sessions as required by the protocol in effect on April 29. The sessions were conducted during the weeks and days leading up to the execution and consisted of planning meetings, on-the-job training for each of the respective positions in the execution chamber and executioners' room and walk-through training sessions for all involved staff members. The paramedic, physician and the three executioners were not included in this training prior to the day of the execution. The final training session included DOC administrative staff reviewing the sequence of events with all parties in the execution chamber just prior to the execution.

Field Memorandum OSP-040301-01, *Procedure for the Execution of Offenders Sentenced to Death*, outlines the training requirements that should occur prior to an execution. The following is a summary of the training procedures that were conducted prior to Lockett's execution.

1. A deputy warden or designee was required to review the sequence of events inside the executioners' room with the executioners and paramedic prior to each execution. Documentation and interviews substantiated

this requirement was completed on April 29 at 5:06 p.m.

2. The paramedic was required to give the following instructions to the executioners, "Administer the drugs at a steady flow without pulling back on the plunger of the syringe." The paramedic did not give this statement prior to this execution. However, the three involved executioners had been involved in multiple executions prior to Lockett's and each acknowledged their roles and duties. The paramedic also acknowledged his/her role to ensure the executioners did their job aseptically, at the correct time, speed and dosage.

3. The warden was required to review the sequence of events with the physician and other DOC personnel in the execution chamber prior to beginning the execution. Interviews and documentation indicated this occurred on April 29 at 5:15 p.m.

4. DOC protocol required the strap-down team to conduct a walk-through of the strap-down procedures no later than two weeks prior to the execution. There were multiple walk-through training sessions conducted prior to Lockett's execution. The last session was conducted within two weeks of Lockett's execution, as required by protocol.

This investigation revealed areas of training that need to be addressed. It was noted there was no formal training process involving the paramedic, the physician or the executioners and their specific roles. They were not involved in any pre-execution training

or exercises to ensure they understood the overall process. For those individuals, the current protocol had very minimal training requirements. The executioners only receive formal training from the paramedic on the day of the execution and informal training from previous executioners during actual executions.

Warden Trammell and Director Patton both acknowledged the training DOC personnel received prior to the execution was inadequate. Warden Trammell stated the only training she received was on-the-job training and that DOC had no formalized training procedures or processes concerning the duties of each specific position's responsibility. The warden and director both indicated DOC had no training protocols or contingency plans on how to proceed with an execution if complications occur during the process.

I. Contingency Planning for Executions

The DOC execution protocol in effect on April 29 had limited provisions for contingencies once the execution process began. One contingency allowed the physician to assist with initial IV access and the other concerned life-saving measures if a stay was granted. After it was determined that problems were present during Lockett's execution, personnel involved with the execution were unaware of how to proceed due to the lack of policies and/or protocols in place at that time. It was determined that no contingency actions were taken inside the chamber other than the physician attempting to locate the femoral vein on Lockett's left side, which was never completed prior to his death.

J. Cessation of Execution Protocols

When an issue with the administration of execution drugs was discovered, the blinds between the chamber

and viewing room were lowered. Several conversations took place inside and outside the chamber regarding how to proceed. The conversation outside the chamber included whether to continue or how to stop the execution. The conversations inside the chamber included whether to provide life-saving measures.

Outside the execution chamber, there were several conversations between Director Patton, Secretary Thompson, OAG representatives at the execution and General Counsel Steve Mullins with the Governor's Office. It was determined between Director Patton and General Counsel Mullins, who had conversed with the Governor, that the execution would be stopped. Director Patton then relayed to the witnesses and the personnel in the chamber that the execution was being stopped. In an additional conversation, General Counsel Mullins further told Director Patton that they would begin preparing a stay at the direction of the Governor. Lockett died prior to the order for a stay being relayed to the personnel inside the execution chamber. There was conversation inside the chamber about administering life-saving measures to Lockett, including transporting him to the emergency room, but no order was given.

K. Two Executions Scheduled on the Same Day

It was apparent the stress level at OSP was raised because two executions had been scheduled on the same day. This was the first time since 2000 two offenders were scheduled to be executed the same day. Four days prior to the execution, the protocol was revised to accommodate the logistics for two offenders.

Several comments were made about the feeling of extra stress. Warden Trammell believed this caused extra stress for all staff. The paramedic stated he/she

felt stress and a sense of urgency in the air. This was based on him/her having been involved in numerous executions.

L. Maintenance of Daily Logs

In accordance with protocol, OSP staff maintained a daily log of events and occurrences related to Lockett. Protocol stated, "Seven days prior to the execution of an offender sentenced to death, a daily log will be kept regarding every aspect of the proceedings except names." This investigation determined the information recorded on the logs was incomplete.

M. Use of Midazolam, Vecuronium Bromide and Potassium Chloride

The new three drug protocol utilized in this execution included the administration of midazolam, vecuronium bromide and potassium chloride. It was determined vecuronium bromide and potassium chloride had both been used in previous executions as the second and third drugs to be administered. This was the first Oklahoma execution where midazolam was used.

On April 14, midazolam was the newest drug added to the protocol after it was determined pentobarbital was not available. Pursuant to the death warrant, a dosage of 100 mg was ordered and administered to Lockett. According to protocol, vecuronium bromide was to be administered at a total quantity of 40 mg and the potassium chloride at a total quantity of 200 meq. These dosages were equivalent to the quantities used in other Oklahoma three-drug methods dating back to at least 2011.

This investigation could not make a determination as to the effectiveness of the drugs at the specified

concentration and volume. They were independently tested and found to be the appropriate potency as prescribed. The IV failure complicated the ability to determine the effectiveness of the drugs.

On the day of the execution, OAG representatives presented an affidavit to Warden Trammell related to the execution drugs. The warden signed the affidavit and attested that the drugs had been obtained legally from a licensed pharmacy and had been handled appropriately, since their acquisition. Interviews of DOC and OAG staff revealed this type of affidavit had been signed in the past, but never on the day of an execution. According to OAG representatives, the affidavit was executed on the day of the execution, due to ongoing litigation concerns regarding the drugs.

N. Historical Incident Reports and Medical Records

The investigation team obtained historical incident reports, emails and medical records from OSP regarding Lockett. The incident reports included approximately 42 instances where Lockett was disciplined for behavioral issues and for contraband located or suspected by DOC personnel. Examples include:

1. A cellular telephone was discovered in Lockett's cell several months prior to the execution;
2. DOC personnel suspected Lockett had been hoarding Vistaril (hydroxyzine) from a prescription that ended March 3;
3. A homemade rope was discovered on the floor of Lockett's cell during his extraction on the day of the execution;

4. A razor blade from an issued, disposable shaving razor was discovered in Lockett's cell on the day of the execution.

The review of Lockett's medical records by a medical professional indicated that he had no past medical conditions or factors that would be considered problematic for IV insertion or drug administration.

O. Lockett's Movements and Sounds after Drug Administration

The description of Lockett's movements and sounds varied among the witnesses. The movement descriptions ranged from quivering to thrashing, but most agreed Lockett's head did rise off the table. There were differing recollections regarding whether Lockett's eyes opened after he was deemed unconscious. The sound descriptions varied from mumbling to Lockett making statements. The recollections varied greatly; therefore it was difficult to determine what was said, if anything.

Several conclusions were made pursuant to the execution table assessment. While strapped to the table, the team member made attempts to move all parts of his body. He was able to rotate his feet inward and outward, move his shoulders slightly and his head had a full range of motion. He was not able to bend or move his knees and had minimal movement in his hips as he attempted to move from side to side. He could not move his hips up and down. The hands had no movement and the arms had minimal movement due to the elbow having limited motion. Based on what was observed, witnesses would have a different perspective of the amount of movement depending on where they were seated. Due to the restrictiveness of

the straps, the movements were minimal to non-existent with the exception of the head and feet.

IV. RECOMMENDATIONS

Based on the findings, the following recommendations are made for future lethal injection executions in Oklahoma. DOC, the Office of the Attorney General and any other entity or individual responsible for execution protocols in this state are urged to thoroughly research, review and deliberate these recommendations prior to their implementation. Further, DOC should review and consider policies and protocols from other states responsible for executions. Any changes to the current policies and protocols should comply with Oklahoma and federal law.

A. Observation of IV Insertion Point(s) and Infusion

1. The IV catheter insertion point(s) should remain visible during all phases of the execution and continuously observed by a person with proper medical training in assessing the ongoing viability of an IV. This person should remain inside the execution chamber during the entire process.

2. Once the appropriate saline infusion has started, it should not be stopped, except for the times that execution drugs are being administered. It should be continuously monitored to assist in ensuring IV viability in accordance with current medical practices and standards;

3. After one hour of unsuccessful IV attempts, DOC should contact the Governor to advise the status and potentially request a postponement of the execution.

B. Training and Maintenance of Execution Log for Condemned Offenders

1. Conduct formal, specific training related to information documented on all execution logs.
2. The information to be recorded on execution logs should include, but not be limited to:
    a. all statements or behaviors that could be detrimental to completing an execution;
    b. all meals provided to an offender and what portions of the meals the offender consumed or refused;
    c. all medication provided to an offender and the observations made by personnel as to whether the offender ingested the medication as prescribed;
    d. all liquids consumed by the offender.

C. Additional Execution Supplies

DOC should maintain and provide their own equipment and supplies ensuring their operability prior to each execution.

1. DOC should obtain from the selected pharmacist, one complete, additional set of each execution drug being utilized for an execution to be used in the event an issue arises with the primary set.
2. DOC should consult with appropriate medical personnel to determine any and all supplies or equipment necessary including, but not limited to the following:
    a. Heart monitoring equipment;
    b. Venous ultrasound equipment;

c. Appropriate needle/catheters to coincide with the IV access options listed in protocol.

D. Contingency Plans in Protocols/Policy

DOC should evaluate and establish protocols and training for possible contingencies if an issue arises during the execution procedure. DOC should consider planning for contingencies including, but not limited to:

1. Issues with execution equipment or supplies;
2. Issues with offender IV access, including obtaining alternate IV access site(s);
3. The offender is not rendered unconscious after execution drug administration;
4. A combative offender;
5. Unanticipated medical or other issues concerning the offender or an execution team member;
6. Issues regarding order, security or facilities at OSP.

E. Formal and Continuing Training Program for Execution Personnel

DOC should establish formal and continual training programs for all personnel involved in the execution process. They should explore successful training procedures used by other correctional institutions and implement accordingly.

F. Formal After-Action Review of the Execution Processes

At the conclusion of each execution, all personnel with assigned execution duties should attend an after-

action review. The review should be completed within five business days and conducted by the director or his designee. The events that occurred during the execution should be discussed in detail and each involved person should discuss their responsibilities and observations. The review should serve as an opportunity for all involved personnel to voice their opinions, concerns and/or recommendations in order for continuous improvement to the process. The review should be formally documented and retained for future reference.

G. Defined Execution Terminology

It was apparent during this investigation that specific terminology should be clearly defined so they are understood by all personnel involved in the execution process. This will allow DOC, OAG and Governor's Office personnel to have a common understanding of how each term affects the execution process and the actions that should take place, if such terms are used. Defined terms should include, but are not limited to "stop," "stay," and "halt".

H. Completion of One Execution per Seven Calendar Days

Due to manpower and facility concerns, executions should not be scheduled within seven calendar days of each other.

I. Updated Methods of Communication

The current communication methods used during the execution process are antiquated and require unnecessary multi-tasking from key personnel in the execution chamber. DOC should explore options on how to update the following:

1. Communication between the execution chamber and executioners' room.

    a. DOC should research and implement modern methods that allow personnel in these two areas to communicate clearly.

    b. The current processes, including the use of color pencils and hand signals, could be used as a contingency if other modern methods fail.

2. Communication between DOC and the Governor's Office.

    a. DOC should research and implement methods to modernize the communication link that would allow direct, constant contact between the personnel in the execution chamber and the Governor's Office.

J. Disposition of Executed Offender's Property

DOC should explore maintaining an executed offender's personal property and any items removed from his/her cell until the autopsy report is completed. This would allow DOC administrative personnel time to determine if such property should be maintained for an additional period of time, if appropriate circumstances exist. In any event, no property should be released until it has been properly searched and inventoried.

K. Execution Witness Briefing

As a result of the changing execution protocols and procedures, DOC should conduct a prepared pre-execution briefing with all attending witnesses. This briefing should include, but not be limited to the following:

1. An overview of the events the witnesses will view during the execution process, including an explanation that witnesses will not be allowed to view all aspects of the execution;
2. Requirements regarding the conduct of witnesses throughout the process.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-665-F

CHARLES F. WARNER, ET AL.,

Plaintiffs,

vs.

KEVIN J. GROSS, ET AL.,

Defendants.

TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING BEFORE THE HONORABLE STEPHEN P. FRIOT UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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* * * *

[396] THE COURT: We'll now have the defendants' out-of-time witness.

MR. STEWART: The defendants call Captain Jason Holt, Your Honor.

THE COURT: Very well.

JASON HOLT,

(WITNESS SWORN.)

DIRECT EXAMINATION

BY MR. STEWART:

Q. Please state your name for the record.

A. Jason Holt, H-O-L-T.

Q. And what is your occupation?

A. I am a captain with the Oklahoma Highway Patrol.

Q. Captain Holt, how long have you been with the highway patrol?

A. Approximately twelve-and-a-half years.

Q. And during that time, what positions have you held?

A. For the first—for the first approximately four years, I was assigned to a field troop, a road trooper, which you would normally think of a highway patrolman to be. For the next approximately seven years, I spent in investigations. About two of that or so as a trooper and about another five or six of that as a lieutenant. And then in November of 2013, I was promoted to the rank of captain and actually have a field command at this point at Troop B in Tulsa.

* * * *

CROSS EXAMINATION

[428] Q. And were you in on each conversation with the medical expert?

A. No.

Q. And is there any report from this medical expert regarding what information he provided you?

A. There is not.

Q. And is there any memorandum of the conversations that you had or your investigators had with this medical expert?

A. There is not.

Q. And so in the some 5,000 pages of documents that we received from the Department of Public Safety in support of your executive summary, is there any information in there that provides information about what this medical expert would have provided as far as consultation?

A. There is not.

Q. What technical aspects related to medical procedures did he provide consultation on?

A. You know, again, we asked him about needle and catheter lengths. We asked him, you know, about the IV insertion process itself. If—you know, for example—and I don't remember everything that we asked him. But, for example, was it normal to start, you know, in the arm, as they started; is it normal to attempt in the jugular; what a "subclavian" is. Those kind of conversations are what we had with that person.

Q. Did you specifically ask him about the pharmacological [429] characteristics of the drug midazolam?

A. I do remember asking him generally what that would be used for in a medical setting. I do remember asking him that, yes.

Q. And was that the extent of his consultation on the drug midazolam?

A. Yes. We did not ask that medical person anything about what drug should have been used, how they could have been used, as far as it relates back to an execution.

Q. So even in what questions you asked him about midazolam, that related only to what that drug is used among doctors for therapeutic reasons for patients?

A. Yes.

Q. Did you discuss with him or consult with him on the pharmacological characteristics of vecuronium bromide?

A. Again, just what that drug would be used for. I don't know if the correct term would be "therapeutic," because I'm not a medical professional, but in a hospital setting what that would normally be used for.

Q. What did you learn from him about how that drug is used in a setting for a patient?

A. That it is a—let me think of the word. And I believe—and I'm not certain of the specific word he used, but what I took was that it was a paralytic.

Q. Okay. And that—was that the extent of what he provided you on vecuronium bromide?

* * * *

[446] Q. And there were two witnesses that expressed those particular words, weren't they?

A. I'd have to go back and read, but I remember at least one.

Q. And both of those, Ilinda Jackson and Edith Shoals, were ODOC victim/witness liaisons, I believe.

A. I believe so.

Q. And you would rely on the transcripts if those transcripts report that that's what those witnesses heard?

A. Yes.

Q. And there were multiple witnesses that heard mumbling, thought they heard words, but they couldn't really understand the words?

A. Yes, ma'am.

Q. Now, isn't it true your mission was limited, at least at the time the executive order was entered, to what the governor asked you to do?

A. Yes. The scope of our investigation was directly governed by that document.

Q. And one of those things was to determine the cause of death?

A. For the medical examiner's office to determine the cause of death, yes.

Q. And you relied on SWIFS for that?

A. Yes, ma'am.

Q. And whether DOC followed their own protocol?

[447] A. Yes, ma'am.

Q. And recommendations for improvement in the execution protocol?

A. Yes, ma'am.

Q. And you did not see it as your mission to actually investigate the drugs, particularly midazolam, that was being used under the protocol?

A. No, ma'am.

Q. Or to recommend any changes regarding the drugs that were used?

A. No, ma'am.

Q. Now—and your investigation really made no determination at all regarding the effectiveness of the drugs that were used?

A. We did not.

Q. At the concentrations that were given or the volume that was given?

A. No, ma'am.

Q. Now, you've recently taken a tour of the facility.

A. Yes, ma'am.

Q. Now, that's not part of your DPS investigation, is it?

A. It is not. It's not part of the executive summary or of the 5,000-page report that you referenced earlier.

Q. And so that tour, was it taken for the purposes of this litigation?

A. That tour was scheduled—we were going to do it at least

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

Case No. CIV-14-665-F

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TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING BEFORE THE HONORABLE STEPHEN P. FRIOT UNITED STATES DISTRICT JUDGE
DECEMBER 17, 18 AND 19, 2014
9:00 A.M.

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* * * *

[682] Feasible alternatives exist that are not required under these circumstances. Feasible alternatives are required only for—and this is a—these words are quoted from Baze, grounds such as those asserted in Baze. Grounds such as those asserted in Baze. That can be found at page 61.

Our grounds are not like those asserted in Baze. The lethal-injection protocol at issue is not similar to Baze.

Defendants have also cited the Chavez case, but only Judge Carnes—this was an opinion of—with three different judges writing. Only Judge Carnes' opinion endorsed their proposed feasible alternative requirement. There is no such requirement in a case such as this.

If Oklahoma's method is infirm, and it is, plaintiffs need not show an alternative to prevent defendants from inflicting a torturous death.

Now, there are alternatives, of course, but plaintiffs need not promote or show them. For the reasons advanced in our proposed findings and conclusions, supported in our trial brief, and as shown at this hearing, this Court should grant a preliminary injunction. And I would—

THE COURT: Let me ask you a question. Apart from how one might read Chief Justice Roberts' opinion, plurality opinion in Baze, if a prisoner is before the Court having had his full run of direct and collateral review and he takes the position I don't—this is unconstitutional and I don't have [683] to come up with any alternative, is that not essentially a successive writ attack on the sentence itself?

MR. BAUMAN: No, Your Honor, because there are other potential methods available. And, you know, we don't have to show those methods, I don't think, and we have to promote them. There are other methods that exist. There's more than one way of killing somebody.

THE COURT: I'm just supposed to imagine there's some available alternative?

MR. BAUMAN: Well, there are some, and some of them have been I think some potential ones, if the state's theory is correct, it's not, though, they become apparent today, and then there are some in the state statute.

THE COURT: Well, historically, the most foolproof method—and every single method of execution has had mishaps. I think history proves

that. Historically, the most foolproof method is firing squad, and it has had mishaps, but the most foolproof method is firing squad.

So how far—what's the available scope of alternative methods that I have to think about in order to decide whether there is, in fact, an available alternative?

MR. BAUMAN: Our argument is that you don't have to think about any, Judge. You just have to think about whether this method that the state is proposing to execute four people with in the next few months is torturous method. We're not [684] talking about mishaps, Judge. We're talking about a method that doesn't work.

THE COURT: Okay. Taking that on its own terms, if you have successfully established that Chart D is a method that doesn't work and you're not acknowledging any obligation to propose any alternative, why—again, why is that not a successive writ, an impermissible successive writ?

MR. BAUMAN: Because the state itself knows that there are other ways of going at this. We don't have to endorse those ways.

I'll add one thing, Judge. We have said that sodium thiopental has come off patent, so we have pled one.

THE COURT: You haven't proven a thing about any alternative. You have not proven a single thing about any alternative drug. There's been questions that presuppose that sodium thiopental has come off patent; there's no evidence of that. There's no evidence that it would be available, compounding or otherwise, if it has. You haven't proven a single iota of anything about any alternative.

MR. BAUMAN: Judge, we have the case that we have, obviously, but on the point that I wanted to make today is that, under Baze, the plaintiffs don't have an obligation to prove an alternative.

THE COURT: Very well.

MR. BAUMAN: Thank you.

[685] MS. KONRAD: I was going to just wait for rebuttal after Mr. Bauman spoke, but I just wanted to make two points.

One, the—it's uncontested in the answer that the defendant submitted that sodium thiopental is no longer—the patent has expired, so just so you know that.

And it is not a successor writ of habeas, because the plaintiffs are not saying that the defendants cannot execute them ever. They're not contesting their sentence. They're contesting the fact that, under the Eighth Amendment, the defendants cannot execute them in a cruel and unusual manner.

THE COURT: Very well. I'll hear from the defendants.

MR. HADDEN: Just briefly, Your Honor. I wanted to run through just a little bit of the three factors that you had identified to us earlier.

Method A and B, they are massive overdoses of barbiturates. Their expert, Dr. Lubarsky, he was very fond of barbiturates and talked about them to great effect when he was criticizing midazolam, but when I tried to ask him about them, he didn't want to answer.

But the point of that that I'm trying to make is that those are well-accepted, but they're not available. It's

one thing to say that the patent has expired on sodium thiopental, but that does not equal availability.

We could say the patent has expired on any number of

IN THE DISTRICT COURT OF OKLAHOMA COUNTY
STATE OF OKLAHOMA

Case No. CV-14-330

CLAYTON LOCKETT and CHARLES WARNER,

Plaintiffs,

v.

EDWARD EVANS, in his Official Capacity
as the Interim Director of
THE OKLAHOMA DEPARTMENT OF CORRECTIONS and
THE OKLAHOMA DEPARTMENT OF CORRECTIONS,

Defendants.

AMENDED PETITION FOR DECLARATORY RELIEF AND REQUEST FOR INJUNCTION

Plaintiffs Clayton Lockett and Charles Warner ("Plaintiffs"), seek declaratory and injunctive relief, pursuant to 12 O.S. § 1651 against Interim Director Edward Evans and the Oklahoma Department of Corrections for violations of Plaintiffs' due process rights guaranteed by the Constitution of the State of Oklahoma, which violations are unconstitutionally preventing Plaintiffs from vindicating their state constitutional rights against cruel and unusual punishment. Plaintiffs also seek declaratory and injunctive relief for violations of the Oklahoma Administrative Procedures Act, 75 O.S. § 250.3. Plaintiffs further plead as follows:

* * *

requirements of the Administrative Procedure Act and therefore violates the Act. *See* 75 O.S. §§ 250.3(17), 303.

12. On January 3, 2014, the Department of Corrections received an Oklahoma Open Records Act request asking for information about the source of the drugs the Department is currently using for executions. The Department has not responded to that request. Subsequent requests similarly have failed to produce any substantive information about the manner or means by which Defendants plan to execute Plaintiffs.

13. Since 2010, pharmaceutical companies' increasing discomfort with their products being used in executions has drastically restricted the availability of legally obtainable execution drugs. In 2010, Hospira, the only FDA-approved manufacturer of sodium thiopental in the United States, stopped manufacturing the drug in this country.

14. Based on representations made by the Department of Corrections in 2011, in either 2010 or 2011, Defendants began using pentobarbital in place of sodium thiopental to carry out executions.

15. In 2011, Lundbeck, the sole FDA-approved producer of pentobarbital in the United States, began blocking supply of its drug to U.S. corrections departments.

16. Defendants used their last known dose of FDA-approved pentobarbital when they executed Michael Hooper in August 2012.

17. Although the unavailability of sodium thiopental and the restrictions placed on FDA-approved pentobarbital surely required Defendants to revise their execution protocol, Plaintiffs have been unable to

obtain any current information about how Defendants plan to execute them; what drugs will be used in their executions; where,

* * *

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No. 14-7955

In The
Supreme Court of the United States

Supreme Court, U.S.
FILED
MAR 9 - 2015
OFFICE OF THE CLERK

RICHARD E. GLOSSIP, ET AL.,

Petitioners,

v.

KEVIN J. GROSS, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

JOINT APPENDIX – VOLUME II (REDACTED)

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TABLE OF CONTENTS

Page

Excerpt of Pls.' Ex. 12, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Michael Oakley (June 10, 2014)).....1

Excerpt of Pls.' Ex. 10, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Anita Trammell (June 2, 2014)) 13

Excerpt of Pls.' Ex. 11, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Robert Patton (June 3, 2014)).....31

Excerpt of Pls.' Ex. 94, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Ilinda Jackson (May 14, 2014)) 37

Excerpt of Pls.' Ex. 36, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Redacted # 7 (May 20, 2014)).....41

Excerpt of Pls.' Ex. 26, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Redacted # 13 (May 20, 2014)).....44

Excerpt of Pls.' Ex. 19, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of John Hadden (May 15, 2014)) 53

TABLE OF CONTENTS – Continued

Page

Excerpt of Pls.' Ex. 39, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Paramedic/Emergency Medical Technician (May 23, 2014))....61

Excerpt of Pls.' Ex. 40, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) (Okla. Dep't of Pub. Safety Interview of Physician (May 27, 2014))....65

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TRANSCRIPT OF RECORDED INTERVIEW
OF
MIKE OAKLEY
BY
CAPTAIN JASON HOLT
TROOPER KEVIN LOGAN
CASE NUMBER 14-0189SI
ON JUNE 10th, 2014, AT 12:58 P.M.

* * * * *

* * *

[8] MR OAKLEY: [redacted]

CAPTAIN HOLT: Litigated and found to be

MR OAKLEY: Yes,

CAPTAIN HOLT: Proper?

MR OAKLEY: Yes, well

CAPTAIN HOLT: Okay.

MR OAKLEY: Well we had the, the protocol that we had before our pharmacist told us [redacted] wasn't going to sell, it had been appealed to the 10th Circuit and upheld and it had been denied cert in the Supreme Court of the United States. We were gold. . .

CAPTAIN HOLT: Okay.

MR OAKLEY: With that, with that protocol, but we couldn't get the drug.

CAPTAIN HOLT: Okay,

MR OAKLEY: So, back up a little bit. We, we, we couldn't fine Pentobarbital, [redacted] and we also had testimony from Dr. Derschowitz, who was our expert witness who had testified in the Florida case that, that he used this drug to administer sedation, And basically that's the purpose of the first drug is to admin, is to get the inmate sedated. Not to kill them, but just to sedate

* * *

[12] pharmacists. One would have been done it.

CAPTAIN HOLT: Okay. When, when protocols change like that

MR OAKLEY: Yes.

CAPTAIN HOLT: It's going back and forth and there are changes being made, and, and you mentioned that the administrative or the procedure officer at O.H.P. has a hand in it, you have a hand in it, it sounds like the A.G. office has a hand in it . .

MR OAKLEY: Yes,

CAPTAIN HOLT: Who, who has the final say, who's the final ruler on, this is it?

MR OAKLEY: Well you know the protocol itself says that the, the warden and the director are responsible for the protocol.

CAPTAIN HOLT: Mm-hmm.

MR OAKLEY: And so I think that, you know, probably the warden and ultimately the director and in that case, you know, I represent the director.

CAPTAIN HOLT: Mm-hmm.

MR OAKLEY: So it would be, it would be me to decide whether it was all pulled together or not.

CAPTAIN HOLT: Okay,

MR OAKLEY: Yeah, it would be the General Counsel.

CAPTAIN HOLT: So D.O.C., not the AG's office would have the final say in . .

MR OAKLEY: Well, you know, here's the deal. We had testimony from our expert witness, if there was anything, I, I depended on them to have that, because, I, I, they had Dr. Darsworth's testimony, I mean from the Attorney General's office in other states.

[13] CAPTAIN HOLT: Mm-hmm.

MR OAKLEY: I didn't have that. So if there was something about the drugs or administration of drugs that was related to the legal aspects of it, I was dependent upon them. But as far as the mechanics of it, I was dependent upon the warden to tell me, "Mike, that's not, that's not working, that's not going to work." And then I would just have to tell the Attorney General's office, "The warden says that not going to work." So.

CAPTAIN HOLT: Okay.

MR OAKLEY: But as far as the mechanics go, I think the, the warden, yeah, yeah I think the warden would be telling me, "Mike, that won't work." Yeah.

CAPTAIN HOLT: Before we deviate off that, when we talk about Dr. Dershowitz.

MR OAKLEY: Yes.

CAPTAIN HOLT: You talk about his expert testimony, the AG's office got that . .

MR OAKLEY: They, they had transcripts of his, of his testimony.

CAPTAIN HOLT: Okay, so they never met with them face to face?

MR OAKLEY: No, no, no, no, not, not for this revision. [redacted]

[redacted] And so, and as far as the dosage and the amounts that he testified too, he wasn't going to say anything different on the witness stand here in Federal Court that he would have [14] said, and as a matter of fact, they may have, the judge may have even allowed us to introduce that, because it was sworn testimony. So there was really no need, to meet, from a legal perspective to meet with him.

CAPTAIN HOLT: Would the warden have, would the current warden have been consulted on the change of the protocol as far as the drugs were concerned in the March . . .

MR OAKLEY: The drugs.

CAPTAIN HOLT: Time frame.

MR OAKLEY: No.

CAPTAIN HOLT: Do you know if she was consulted at all?

MR OAKLEY: You know; I think that she was dependent on us, the Attorney General's office and my office to, to tell her what we thought from a legal perspective because she knew that the first drug was only for sedation purposes and that's what we were changing is the first drug. The ultimate drug that would kill someone was Potassium Chloride. It was the last drug administered and that was the drug that was in the cocktail to actually render death.

CAPTAIN HOLT: Okay,

MR OAKLEY: And we still had the Potassium Chloride.

CAPTAIN HOLT: Okay. Who, so kind of wrap this part up about the protocol, the three drug protocol and getting this ready for this execution. You, John Haden, Kendi Jones . . .

MR OAKLEY: Jennifer Miller.

CAPTAIN HOLT: Jennifer Miller, anybody else that would have played a part in, in putting this together?

MR OAKLEY: Well I know Seth, gosh what is Seth's last name? I can't remember his last name. He, he was actually, he was the one going over [15] the testimony, he's the one who had the testimony. He, he, he was the assistant over, the assistant over the Attorney General that works for Jennifer.

CAPTAIN HOLT: Okay.

MR OAKLEY: And I know if, I think this was his case.

CAPTAIN HOLT: Okay.

MR OAKLEY: And he was looking for, looking at that testimony. As far as looking for drugs, we were all looking for drugs. Me, Jennifer, Seth, everybody was looking for drugs, so.

CAPTAIN HOLT: In, in the several years up, leading up to this specific execution, the administrative part of the protocol, has that changed much? Or do you know?

MR OAKLEY: No, well there was a, there was a case, and, and I, believe me the cases just kind of run together after all these years.

CAPTAIN HOLT: Yes sir.

MR OAKLEY: But there was a case where we decided to settle the case. We decided to wait for five minutes between the administration of the first drug and to do a consciousness test to make sure that the offender was unconscious and rendered sedated by that first drug, and so there was a, and I cannot remember the case, but there was one case where we was settled that. There was another case where they talked about, well do you have other drugs available? And that's where we built in the redundancy in the system the left arm, the right arm, there is redundancy, twice as many, twice as many drugs are administered to the body and that's when we developed that. And so for, for, to, to change anything regarding the administration of that drug, really was something that you had to look at very, very carefully because it had been litigated.

CAPTAIN HOLT: Mm-hmm.

* * *

[32] Court, they would say, "No." So they went through State Courts and because of that and the

way it worked out because of the way, the the Supreme Court ruled, they weren't getting Stay's the way they thought they were going to get Stay's. So it was a little bit different legally, so there may have been a reason legally for them to be seeking affidavits at that stage, I don't know. But it, no, it had never happened before. We never had an aff, the warden had never had to sign an affidavit saying, "Yeah, I got these drugs and the Chain of Custody was, was proper." No. That, that's nothing we ever did.

TROOPER LOGAN: You had mentioned earlier that you had researched the Midazolam.

MR OAKLEY: Yes.

TROOPER LOGAN: In what ways?

MR OAKLEY: Well, You know. . .

TROOPER LOGAN: I mean we all research kind of in different ways.

MR OAKLEY: [redacted]

TROOPER LOGAN: Okay. You had.

MR OAKLEY: And also, in, [redacted]

[32] [redacted]

TROOPER LOGAN: [redacted]

MR OAKLEY: [redacted]

TROOPER LOGAN: Do you kind of recall at all when that conversation took place? Was it over the phone? Was it in person?

MR OAKLEY: [redacted] So I don't know remember what day it was, but I do remember calling her because I thought, you know, [redacted]

[redacted] And I really felt kind of bad for the warden because she was fairly new, and [redacted]
[34] [redacted]

TROOPER LOGAN: So you mentioned that, she was kind of out of the loop on a lot of this and that, you had also mentioned earlier that she, her and the director, ultimately would, and/or should have had a say so when it comes to change in protocol.

MR OAKLEY: Oh yeah. I think they should have.

TROOPER LOGAN: So going back and looking at the protocol as it was changed, and looking at the drugs when we change, and when you guys changed the protocol here, and I say, "you guys," D.O.C. and the AG's office, do you feel like the warden had any input or do you feel like she was left out of the loop in that?

MR OAKLEY: Well I, I did think, I tried to bring her up to speed, I really did, She, she was not saying, "Oh we need to use Midazolam." No she wasn't. She was saying, "Is this going to do the same thing that Phenobarbital did, and what do I need to know about that," kind of questions. I don't, I feel like she could, I think there was a lot of pressure put on her and a lot of responsibility that she didn't really have the authority, the responsibility without authority. And that happens a lot in agencies, you know, you know that, probably from your own agency. But you know, I don't work there anymore so I can be honest

with you. I feel like, I feel like you know, that's the reason I tried to bring her in a little bit more, and I had to make an effort to do that because things were changing fast. Things changed fast during this litigation. Things changed fast and they changed, I'm sure from the time I left on the 23rd to the 29th. I'm sure they changed several times since then, you probably know better than I do how they changed. So it's, you know, it's one of those things were you had to make a constant effort to try to bring Anita into the loop because decisions were being made, legal decisions, from a legal standpoint were being made where she, [35] she wasn't really brought into all those decisions.

TROOPER LOGAN: Okay, so it would be fair to say, well, let me ask you this, so you had mentioned copies of the protocol, maybe at times you didn't have copies of them would it be fair to say that she never saw a copy of the protocol before it was ever enacted?

MR OAKLEY: I don't, see, well that's possible. I mean, it, it's quite possible that if they changed it after I left, that she wouldn't have, I don't know.

TROOPER LOGAN: Prior to you, prior to leaving there?

MR OAKLEY: Prior to me leaving. No she had to sign the protocol before. She had to sign it.

TROOPER LOGAN: Okay.

MR OAKLEY: We, yeah, she did have to sign it. I, I, I'm rewinding it here a little bit.

TROOPER LOGAN: Yeah,

MR OAKLEY: We, we had to search her down a couple of times to sign it.

TROOPER LOGAN: Okay,

MR OAKLEY: But yeah she had to have, have looked at . . .

TROOPER LOGAN: She had to see it.

MR OAKLEY: To have signed it. Yeah.

TROOPER LOGAN: Okay.

MR OAKLEY: For it to, yeah, for it to be operative.

TROOPER LOGAN: Okay.

MR OAKLEY: So if there, if there, if it was a signed protocol, then she had to have looked at it.

TROOPER LOGAN: Okay.

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TRANSCRIPT OF RECORDED INTERVIEW
OF
ANITA TRAMMELL
BY TROOPER JASON HOLT
TROOPER KEVIN LOGAN
CASE NUMBER 14-0189SI
ON JUNE 2ND, 2014, AT 12:42 P.M.

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[33] any other observations made by any of your staff up until the 29th that you think we should know about or that we haven't asked about that you think are important?

MS TRAMMELL: I mean

CAPTAIN HOLT: Observations they made that they told you about?

MS TRAMMELL: Well it just concerns me about medical and their observation on his – his veins because right off the bat, the EMT, when [redacted] always goes to the left arm and [redacted] looked at it and [redacted] said immediately that you're an intervenes drug user and he said "Yes, yes [redacted] I am," and so how – if [redacted] recognized that; how come they didn't? Don't know. I mean, it's not the first time we've had issues with our medical department on that. And

then mental health, nothing. I mean he just was on a roller coaster and they just documented his behavior.

CAPTAIN HOLT: What – in protocol, it states that it's the warden's duties to determine what drugs are to be used in the – in the execution. What factors in this case for Lockett lead to those three drugs being used?

MS TRAMMELL: The pharmacists that we had had the phenobarbital and there was a lot of issues with Missouri execution and so that the pharmacist that we was using refused to give the drugs to the department. Refused to deal with the department so we were out of – I mean, we couldn't' get the phenobarbital.

CAPTAIN HOLT: Was that between the – the last execution before Lockett and Lockett's?

MS TRAMMELL: Yes. Yes it was.

CAPTAIN HOLT: Okay.

MS TRAMMELL: And that's some of the reasons for the stays, you know, that – that was happening. So in the meantime, the policy was revised with the drug protocols in there. You know, there was several of them listed, I think five or six and [34] they looked at other state's protocols so I didn't make the decision on the drug.

CAPTAIN HOLT: Okay and that's my next question. What – what other agencies play a role in

preparing for an execution and – and what is their role?

MS TRAMMELL: I – I – all I can say is that I didn't write the policy. I don't know anything about the drugs. I was just – I'm told the drugs that's gonna be used. I didn't pick the pharmacist – pharmacy. Didn't even know which pharmacy it was till it was determined. So I'm not sure how that – how we even secure the pharmacist.

CAPTAIN HOLT: Okay, Does that come from another agency?

MS TRAMMELL: I don't' think so.

CAPTAIN HOLT: You think that come . . .

MS TRAMMELL: I don't but it possibly could.

CAPTAIN HOLT: Okay. What other agencies – are there any other agencies that play a role in preparing for an execution other than D.O.C.?

MS TRAMMELL: Yes.

CAPTAIN HOLT: What agencies are those?

MS TRAMMELL; The Attorney General's office.

CAPTAIN HOLT: Okay.

MS TRAMMELL: I mean they're – they're instrumental with the victims. They have a couple of staff that bring the victims down. Of course they deal

with courts as well, Court of Criminal Appeals and so they're involved if there's gonna be a stay or of there's any question on the legality of the execution as far as if we may have a stay.

CAPTAIN HOLT: Okay. We'll come back to that.

MS TRAMMELL: And they were involved in writing the addendum. They, helped with that, provided assistance with that.

CAPTAIN HOLT: Okay. We'll come back to that. Let me – let me move on and we'll move on and we'll come back to that in a little while. The – you say the

* * *

[25] try real hard to get the vein.

CAPTAIN HOLT: Mm-hmm.

MS TRAMMELL: You know how painful that can be so I was really proud of him for that.

CAPTAIN HOLT: Do they ever ask – they, being the doctor or the EMT – do they ever ask your input about what – what to do while they're trying to find a vein?

MS TRAMMELL: No, no.

CAPTAIN HOLT: Okay.

MS TRAMMELL: And like I said, I try to stay out of their way. 'Cause then, by this time, you

know, it started at 6:23 so kinda lost track of time, but it was getting closer to – for time to start.

CAPTAIN HOLT: Mm-hmm.

MS TRAMMELL: So I thought I gotta stay out of their way and let them do their job. Well when they were working on his neck, they cut his – his – it was a – what do they call – scrubs? And they had cut that, you know, so they could get to it. Had it pulled down and then, then they said they were gonna go to the groin area. So he had on scrubs with an elastic waist band. They cut that on both sides and pulled that down or kinda laid it over and the doctor originally was working on the left side. Couldn't get it and there was blood everywhere, couldn't get it and it looked like to me – I was still sitting down – it looked like [redacted] was kinda jabbing, trying to get that vein. That's how it looked to me, or poking and so then seems like [redacted] was on the right side, but again, I'm not 100%, but [redacted] ended up on the right side and [redacted] found it. [redacted] did that and so [redacted] got it and then, you know, we watched that drip. And I did get up and go look at the drip and [redacted] looked at the drip and I'm pretty sure the doctor did as well. [redacted] was back there in the back and [redacted] knows a lot about the steady flow and [redacted] said it "looks good, looks good." And so I went back there and [26] looked and we – we monitored that for a while.

CAPTAIN HOLT: Okay.

MS TRAMMELL: And actually we had a conversation about this the next day because time, it

was hard to measure time during this period and [redacted], which you guys interviewed, [redacted] thought that we monitored for 15 min. I don't know if [redacted] told you that. That sounds like an awfully long time. I don't think we monitored it that long but we did monitor for a while until they felt comfortable. They meaning the doctor and the EMT. That – that we had a good vein.

CAPTAIN HOLT: Which – which [redacted] said he thought it was 15 minutes?

MS TRAMMELL: [redacted] [ph. sp.]

CAPTAIN HOLT: Okay,

MS TRAMMELL: And [redacted] was just observing. That was [redacted] first time to be in there.

CAPTAIN HOLT: Okay,

MS TRAMMELL: So when [redacted] told me that the next day, I thought I don't know. That seems like an awful long time, but anyway. So they – they went back, after they, everyone felt comfortable in the drip. You know, the steady flow and [redacted] put the covering over the, you know, the needle and all of that and covered him back up.

CAPTAIN HOLT: Who makes the final decision in that room, who's responsible for the final decision of IV placement? Of – of where that is to go if they're having trouble like that?

MS TRAMMELL: I would have to look and see exactly what the policy says. I mean, ultimately

what happens in there I guess is my responsibility but I – I wouldn't know about going to the groin area. I mean, I thought the final – if all else fails you could do the cut down. 'Cause I thought that was fool proof that you do a cut down [27] and you're – you know, you're in.

CAPTAIN HOLT: Okay.

MS TRAMMELL: So when I see that I mean I was . . .

CAPTAIN HOLT: Who made the final decision for Lockett? Was it the doctor or the EMT or yourself?

MS TRAMMELL: I – I'd probably say all three of us.

CAPTAIN HOLT: Okay.

MS TRAMMELL: In – in collaboration on it.

CAPTAIN HOLT: Okay,

MS TRAMMELL: Because I felt comfortable that – I mean I didn't feel comfortable any through that whole process as it progressed because it was just -- I was just getting nervous about what all I was seeing and the difficulties that they were having.

CAPTAIN HOLT: Okay.

MS TRAMMELL: So . .

CAPTAIN HOLT: Who – who made the decision to cover the insertion sight?

MS TRAMMELL: I did.

CAPTAIN HOLT: Did – did they ask you? I mean, is that something that they ask you? Is that a statement you made? How was that decision made?

MS TRAMMELL: I – I don't think it was a deliberate decision. It was just an automatic decision. I mean, you know from where they put that at you could see his privates. You know, I – hindsight if we talk about that, I'll address that . . .

CAPTAIN HOLT: Okay.

MS TRAMMELL: . . . at some point if you want to, but I guess – I guess you could say it was mine.

CAPTAIN HOLT: Okay. Go ahead and finish walking me through from now [28] they have the IV started till the end of the process. Walk me . . .

MS TRAMMELL: Okay,

CAPTAIN HOLT: through that part.

MS TRAMMELL: SO we have – so you can see that there's staging people from H unit up into the chamber. Everyone that's gonna – I mean, you know you could kinda see shadows and that sort of thing and so normally there's, I've had up to 30 minutes to talk the offender about the process and didn't have much time. But I went over there and I

was talking to him. That's when he said his mouth was so dry and you could tell. It was all crusted over and I told you what I did.

CAPTAIN HOLT: What – what do you mean?

MS TRAMMELL: Well I – I wiped his mouth. He asked for that. I wiped his mouth off and then just tossed that Kleenex in the floor which you guys got that.

CAPTAIN HOLT: Okay.

MS TRAMMELL: Remember? But I talked to him a little bit about the drug, what I knew about it. You know, this – it wasn't like the other drug. It was gonna be a slower process and where his attorneys were gonna be at about him making a last statement. He said he wasn't gonna make one and you know, I just didn't have a whole lot of t-time to talk to him because it was way after 6 by then. So after that, the director gets on the phone and they hand the phone to me and he said "We're gonna let the execution begin." I said "Okay." So I walked back over and you know, – of course everyone knows and I told them "Raise the shade" and [redacted] did and [redacted] turned the mike on and look out there and there's so many people. Every seat was full and I – I kinda turned a little bit so [redacted] could see me. I said "Let the exe" – or – no, I – asked the offender if had any – a statement. And I said "Mr. Lockett, do you have a statement that you'd like to make?" And he said "No." And that's all he said and so I turned and said let the

execution process begin and started. Of course I looked up [29] at the clock, or I think I did, I always like to because the 5 minutes standing still is a long time. Let me tell ya. It was a long time and I don't like to look up and down or look out and see who is out there. I don't like to do that. Director Jones, when he was here, he told me it was best just not to. My first execution, those attorneys for the offender was just boo-hooing and crying so I made it a point just to watch the arm. Of course, I wasn't able to with Lockett, but I was watching his face and his expressions and nothing was happening. I mean nothing was happening. Nothing. You know, he was trying to be real patient, it was obvious. He was laying there with his eyes closed and I mean, it just looked like nothing was happening for a while. And then he'd open his eyes and he'd kinda look around and at one point he looked over at me like what – what's taking so long and mean, that's just the expression he gave me and – of course then he started, he closed his eyes and his breathing slowed down just a little bit but I mean, I knew he was still conscious at that five minutes mark when the doctor got up. You know, the light went, goes off and the doctor goes and checks him. You know it was apparent. It was apparent he was still conscious so I – I stated that. I think I said "The offender is still conscious," and so – they didn't do anything and they set the clock again. And when it went off again, the doctor ge – and between that time then his breaking did slow down and you know, his chest wasn't rising quite as much and his face looked like it was getting more relaxed. With the old drug,

the phenobarbital, the offender quickly would take two deep breaths. I mean real quick into and kinda make a snoring sound and the – they just kinda look like they're in a really deep sleep. And then next their color starts changing to ash and then kinda greyish and then they're gone. And that wasn't anything like this drug. At all. But anyway, after the second – after the five-minutes between the five and the next –the – the newspaper said three minutes but we had scheduled for two – but when [redacted] got up again [redacted] said he was unconscious and so I stated that and that's when they started pushing the second [30] drug and – let me look right here, my notes. 'Cause when I wrote this up – the first the I noticed, of course I was watching his face and I was watching his face and I was looking at his chest and everything looked like after he was unconscious, it looked like everything was going okay, just really slow. And then he moved his mouth side to side like that and I thought, that's odd. You know 'cause I've never seen that before. Just kind of twitching to the side. I thought that's odd. And then a little while I – later, and I don't know time frames, but he started shaking, quivering. You know, just all over and I didn't know what to think about that. Just all over and then after that, it looked like he – and his eyes were closed the whole time. Well at some point maybe – maybe before he started quivering, he mumbled something like an odd sound. Odd and then he raised, try to raise his hands and his feet and his head up and we – he did. He raised his head up and at some point he said something and the media said that he said something's wrong. I don't

know if that's what he said or not. It was just something that I recognized. I thought he said something but I can't remember exactly what it was because I was just – you know inside I didn't know what to – I mean, I was kind of panicking. Thinking oh my God. He's coming out of this. It's not working and so he did that and I wasn't sure where the director was sitting at out there, but I looked up to look for the director and he was sitting directly in front of me. So I looked at the director hard like gimme some, you know gimme some pointers or give me some advice and he looked up at the clock, the director did. So I looked back down at Warner, I mean Lockett and he did it again. I looked back up at the director and I knew some – it was going south. Something was definitely wrong cause I thought he was coming out of it and he – it seems like he did a third time, but I can't say that for certain, as far as raising up – but I looked over at the doctor and the doctor was looking at me like something's wrong so I motioned for the doctor to come up and [redacted] looked under there and then [redacted] whispered something in my ear to the affect that [31] the drugs not going into his vein or it's something along those lines. And so, I made the decision to lower the curtain and I – you know, one of the things I should've done is said something. That we had a malfunction with – with the drug or with the vein but I don't know if I said anything. I think I started to say something and it just didn't come out but I should've said something and that would've helped this process. But anyway, we lowered the shades and I have [redacted] I said "I need to talk to the

director. Get the director on the line." Of course, all those people were still sitting out there so it took [redacted] a minute and I guess the director walked out to get on the phone to have a private conversation. So he asked the questions about is there enough drugs – well I told him about, you know, it wasn't going into the vein and so he asked the questions, I don't know exactly, about is there enough drugs to kill the offender. I don't know if used the word kill or not but – and I asked the doctor and [redacted] repeated back "No," and then I said is there enough drugs to – or first question, did he absorb enough drugs and the doctor said no. Then the question was is there enough drugs left and so the EMT kinda went like this and – and the doctor said no. And the director said that's not what I asked. I asked if there was enough drugs absorbed or not absorbed but into his system to, for him to die and the doctor said no. So I told the director that and he said – I don't remember exactly what he said. Hold on or something. So he come back in a little while and – and they were working on the offender, not to revive him. They were working on to check veins and – and see if there was another vein or something else they could do to continue with the execution and then the director come back on and he said stand down maybe? Or hold – we're going to stop the execution. I think that's the words? Or stand down. He used a term that I'm not used to in Oklahoma. Maybe stand down 'cause I've heard him say that before on something, but anyway I said "Do you mean to – to stop?" He said yeah. Which there – I mean, we had already stopped because we wasn't able

to do anything [32] but the doctor was saying "I don't know if there's enough drugs. How am I supposed to know if there's enough drugs to absorb?" But the doctor did say that it looks like it was absorbing into his tissue, you know. The doctor was kind of [redacted] was pretty frustrated. I think [redacted] got frustrated with me but you could tell I mean, after lowered the blinds – and I went back and asked my staff the next day. I said "you know, I do not remember seeing that offender raise up or do anything else after we lowered the blinds." And they said "He didn't." I said I don't recall him doing anything else. So maybe if we had just kept the blinds up, it would've still taken to 7:06, but it's neither here nor there because we did lower the blinds. But he didn't – he wasn't raising up or doing any more of that. But the doctor, I mean, the EKG was, [redacted] was monitoring it and [redacted] was checking his heart and all of that and [redacted] said his, each time [redacted] said his heart beat was getting more faint each time. And I said "Are you gonna call it?" [redacted] said "Not yet." So I asked [redacted] that a couple of times and [redacted] got pretty frustrated with me. [redacted] said "Not yet. I will tell you when I'm gonna call it." So it wasn't like at 7:06 he just died. It's not like at 7:06 he had a massive heart attack and died. He was dying the whole times in my opinion, he was dying the whole time. It was just taking a lot longer because it was absorbing into his system instead of going directly through his vein.

CAPTAIN HOLT: Okay. Can you – lets start here. Can you just write down where once –

once the IV is inserted, can you just write down where everybody was standing at as the drugs were being administered?

MS TRAMMELL: Want me to just write their name or . . . ?

CAPTAIN HOLT: That's fine. Yes that's fine. Except for the – just put physician for physician, EMT . . .

MS TRAMMELL: Okay. [redacted] was back here in this corner and [redacted] had the little remote for the blinds and then the – the mic was right here in this area and

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[61] MS TRAMMELL: That's my mistake for not checking on the IV. It's the department's mistake for not having another plan in place. Which we had the cut down. I thought that was, you know, foolproof. I mean I thought you cut down and you – I mean I've never seen a cut down, but . . .

CAPTAIN HOLT: Is it your opinion that a cut down was done.

MS TRAMMELL: Yes.

CAPTAIN HOLT: Okay.

MS TRAMMELL: Cause [redacted] opened the kit and [redacted] was up there working on him.

CAPTAIN HOLT: Okay.

MS TRAMMELL: I mean [redacted] may have told you something different.

CAPTAIN HOLT: Did .

MS TRAMMELL: Cause I heard [redacted] say "I can't get it. I can't get it"

CAPTAIN HOLT: What other mistakes would you say that – that you, as the warden, made?

MS TRAMMELL: Was not – the mistakes I made was not researching the drugs. Relying on my legal department and the AG's office like I did to just sign in a policy when I didn't write the damn thing. Just trusting and not – I mean – just – just taking, just accepting ownership for something this big without the department's support. Except for this new director.

CAPTAIN HOLT: How about in the execution chamber itself. Would you say that anything was . .

MS TRAMMELL: Yes, you know, I should've done something different with, you know, what I could've done instead of. I mean I think I needed the sheet on him cause you would have seen his privates, but the d – I could've put the doctor over there beside him. Move that EKG where [redacted] could raise it up – where [redacted] could watch

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TRANSCRIPT OF RECORDED INTERVIEW
OF
ANITA TRAMMELL
BY
CAPTAIN JASON HOLT
TROOPER KEVIN LOGAN
CASE NUMBER 14-0189SI
ON JUNE 2ND, 2014, AT 3:44 P.M.

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[11] it and we mailed it back and then there was some more correspondence. And then on 4/11 I was off with [redacted] and I was on the phone a lot with work that Friday, which I dunno what day that was, 14th. I was off out at my parent's. I was mowing and weed-eating. Went and checked my phone there was calls at 3:30 from the facility. So I called the facility and it was Regina. The AG's office, according to her – well Mike, he was off too, wanted me to come in and sign this revised policy on a Friday afternoon and I said no. I'm not going up there. I just signed one policy so I figured I was gonna get my hand slapped Monday, but I didn't. No on even knew anything about it. So Monday, I got the policy. It was revised for the second time, you know, there was a mistake and the mistake was the dosage of the Midazolam and you got that.

CAPTAIN HOLT: Mm-hmm.

MS TRAMMELL: And so I signed the damn thing. I did not write that policy. I did not choose those drugs.

CAPTAIN HOLT: Okay.

MS TRAMMELL: I didn't know – I didn't know anything about the drugs.

CAPTAIN HOLT: Okay. So, Mike Oakley was the representative from the D.O.C. that was involved in that process. Do you know who from the AG's office he was meeting with?

MS TRAMMELL: That I don't know.

CAPTAIN HOLT: Okay. You want me to follow on that part before we –? One of the final parts I wanna make sure that we clear up is the – the stop of the execution. I understand that – that you said earlier that the director told you to stop, halt, stand down, whatever – whatever that conversation was. I just wanna ask, and I think we've answered it so, but I'm just gonna ask again so we can make sure that we clear it up. Why was life saving measures not given to Lockett after the

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TRANSCRIPT OF RECORDED INTERVIEW
OF
DIRECTOR ROBERT PATTON
BY CAPTAIN JASON HOLT
TROOPER KEVIN LOGAN
CASE NUMBER 14-0189SI
ON JUNE 3RD, 2014, AT 9:40 A.M.

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[6] CAPTAIN HOLT: Okay. Um, How long does it take, how long does it take for them to determine how they're going to proceed. So from the time that they, you've got the stay issued, how long is that process before they decide okay, here's what we're going to use and we can find it?

DIRECTOR PATTON: They began searching for another pharmacist at that time. Uh, I found out that they had found a pharmacist and the drugs, uh through a news report. That is how I found out

CAPTAIN HOLT: Okay,

DIRECTOR PATTON: [redacted]

CAPTAIN HOLT: Okay. You say he or are you referring to Mike Oakley?

DIRECTOR PATTON: I am referring to Mike Oakley.

CAPTAIN HOLT: Okay, So, Mike Oakley in the AG's office is who worked to find the new pharmacist and the new drug protocol, what was the drug set to be before that March stay?

DIRECTOR PATTON: It was a three drug protocol, uh it was pancuronium bromide

CAPTAIN HOLT: What was the drug that was changed?

DIRECTOR PATTON: And it was changed to midazolam.

CAPTAIN HOLT: Okay. So the first drug that is used, not the other two, the last two are made the same, just the first drug?

DIRECTOR PATTON: changed to midazolam from what they were using before which was pentobarbital or pancuronium bromide

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TRANSCRIPT OF RECORDED INTERVIEW

OF

DIRECTOR ROBERT PATTON

BY CAPTAIN JASON HOLT

TROOPER KEVIN LOGAN

CASE NUMBER 14-0189SI

ON JUNE 3RD, 2014, AT 11:07 AM

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[5] protocols in the current DOC protocol for executions.

DIRECTOR PATTON: Yes.

CAPTAIN HOLT: Do you know how the decision was made to use the specific one involving the midazolam and not one of the other two, or however many are in the current protocol?

DIRECTOR PATTON: [redacted]

CAPTAIN HOLT: In your media briefing that you had after, that night after the execution, you used the term 'exploded'.

DIRECTOR PATTON: Mm-hmm.

CAPTAIN HOLT: Medically do you know what happened with . . .

DIRECTOR PATTON: No I do not.

CAPTAIN HOLT: . . . Clayton Lockett?

DIRECTOR PATTON: I do not,

CAPTAIN HOLT: Okay. Um . .

DIRECTOR PATTON: The terms I used that night was what was described to me over the telephone.

CAPTAIN HOLT: Okay, What – in any meetings that you have had since the day of the execution.

DIRECTOR PATTON: Mm-hmm,

CAPTAIN HOLT: . . has DOC made any conclusions about what they think went wrong with this execution?

DIRECTOR PATTON: I've been very careful, as my general counselor can testify to, every meeting that we've discussed executions, my statement to staff is very simple. It's under investigation. At the conclusion of the

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[13] Warden.

TROOPER LOGAN: Okay.

DIRECTOR PATTON: But, if you ask the Warden that question, she will tell you she was told what protocol to use.

TROOPER LOGAN: Okay. Do you know who she was told by?

DIRECTOR PATTON: It is my belief, the General Counsel, Michael Oakley, and again, as I've stated earlier, Mike Oakley said this is a decision made by himself and the AG's office, Mr. Hadden.

TROOPER LOGAN: Okay.

DIRECTOR PATTON: But I do not believe the Warden actually chose the protocol.

TROOPER LOGAN: Based upon your understanding, you feel like she was relying on Mike Oakley and the AG's office?

DIRECTOR PATTON: [redacted]

TROOPER LOGAN: Okay,

DIRECTOR PATTON: [redacted]

CAPTAIN HOLT: It's our understanding that they did some vein checks of the offender several days, several times up until that day, were you ever briefed on the results of any of those?

DIRECTOR PATTON: No, sir, I was not.

CAPTAIN HOLT: Have you been briefed since the execution on the results of those?

DIRECTOR PATTON: No, sir, I have not.

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TRANSCRIPT OF RECORDED INTERVIEW
OF
ILINDA JACKSON
BY
TROOPER MATT GOTTSCHALK
CASE NUMBER 14-0189SI
ON MAY 14th, 2014, AT 9:38 AM.

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[14] over at 6:10 that perhaps it's over and we've missed it

TROOPER KRAFT: Yeah.

MS JACKSON: So he, they started checking and it hadn't started, we didn't, we didn't know that it hadn't so we just surmised nobody told us that it hadn't started.

TROOPER KRAFT: Yeah.

MS JACKSON: But we figured out oh, it's delayed something's wrong something hasn't happened yet, so at 6:17, 6:18 about 6:20 so in between 6:20, 6:23 the TV comes on and we began to watch the process. The warden asks to have any last words Lockett said no, and she said let the execution begin. And I stood up to watch because I was just interested – I couldn't, I couldn't tell from the seat ya know, I

wanted to know how the drug moved, I wanted to know if it was as fast and that was the purpose in me getting up.

TROOPER KRAFT: Yeah,

MS JACKSON: And what I noticed immediately was that he was blinking his eyes, he kept doing this, he kept kind of yawning and making faces really yawning or whatever. And we both, me and Edith sort of looked at each other and said is that's unusual, ya know, we sort of looked and thought hmm, that's different.

TROOPER KRAFT: Yeah.

MS JACKSON: And, you know, he kept doing that and kept doing that for a while which I didn't, I didn't there's no clock in there and then eventually the medical examiner stood up. It looked like he had become very still which is the normal process after [redacted] says let the execution begin within a minute the offender doesn't move with the previous drug. With this drug he moved his head back and forth ya know, this kind of stuff. But finally he's still there's no movement and so I don't know how many minutes had passed but [redacted] got up and [redacted] checked his eyelids [15] both eyelids; the left, the right. And then as [redacted] pulled the sheet back to put the thing to check his heart [redacted] said he's unconscious and [redacted] walked away. As [redacted] was walking away or as [redacted] was moving away the offender said this blank is f-ing with me, which is extremely unusual and . . .

TROOPER KRAFT: Go ahead and say it, what did he say?

MS JACKSON: This shit is fucking with me, is what I could make of it. It was kind of gargled but that's what it sounded like. And then, he began to move his head at that point back and forth and began to try to get up off the gurney. Now the reporter said he was convulsing but I kept replaying that in my mind and kept thinking of children I've seen that have had that and it doesn't go from the head forward, it's the head is – everything limp and the body is doing it's own thing but he was fully in control of that so in my opinion I thought he was trying to get up.

TROOPER KRAFT: Yeah.

JACKSON: thought he was fighting the process and was trying to get up.

TROOPER KRAFT: Now was he covered with a sheet?

JACKSON: He was covered with a sheet. He's strapped, you can't see – you know that he's strapped because of how still this is, his arms are this way, strapping's are this way, strapping's are at the bottom.

TROOPER KRAFT: Can you see any IV's anything like that?

MS JACKSON: Well, at one point no, not really. At one point the doctor did get up and walk

over and pull the sheet back to check but you couldn't really see what, just what. And then a few moments later the warden says stop the execution or whatever she said, I don't, I didn't make it, make that out as well. But the curtains came down, the curtains may have came down as she was saying it but they brought the curtains down and we were probably there not even another minute before they

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TRANSCRIPT OF RECORDED INTERVIEW

OF

[redacted]

BY

CAPTAIN PAUL CHRISTIAN

AND CAPTAIN DAMON TUCKER

CASE NUMBER 14-0189SI

HELD IN THE US FEDERAL COURTHOUSE

ON MAY 20, 2014, AT 1:20 P.M.

IN MCALESTER, OKLAHOMA

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[89] CAPTAIN CHRISTIAN: – you know, IV in. Is this – does [redacted] – is [redacted] like an EMT or paramedic or something that? Seems like we read that somewhere.

[redacted] I read that it was EMT but I don't know,

CAPTAIN CHRISTIAN: Okay. Okay. Okay. So does the – the phlebotomist and the doctor stay out here the whole time?

[redacted] Yes.

CAPTAIN CHRISTIAN: Okay. Until Lockett passes?

[redacted] Yes,

CAPTAIN CHRISTIAN: What happened during that time period? Anything?

[redacted] Not really. I mean, like I said the doctor just kept running back and forth from his – from his head area to the monitor just to see if he was – had passed yet. It took a while for him to pass, but –

CAPTAIN CHRISTIAN: So nobody did lifesaving measures on him at all?

[redacted] No.

CAPTAIN CHRISTIAN: Nobody even, did – I guess it was considered by the Warden,

[90] because she asked the question, but nobody felt like they could do anything about it?

[redacted] No.

CAPTAIN CHRISTIAN: Was there a conversation between the doctor and the phlebotomist about that?

[redacted] About the lifesaving measures?

CAPTAIN CHRISTIAN: Uh-huh.

[redacted] Not that I recall.

CAPTAIN CHRISTIAN: And then eventually he was pronounced dead. How – how did –

[redacted] Yes

CAPTAIN CHRISTIAN: – all that happen?

[redacted] kept going back and forth to [redacted] monitor and I don't remember exactly [redacted] words on the monitor activity, but [redacted] said something about the monitor activity and then I guess it kept getting to where he would – where he was passing away. And finally the doctor said, well, he's getting closer or something like that. And the Warden asked [redacted] if – told [redacted] that, you know, you have to give me a time if he does – you know, time of – pronounced death.

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TRANSCRIPT OF RECORDED INTERVIEW

OF

[redacted]

BY

CAPTAIN PAUL CHRISTIAN

AND

CAPTAIN DAMON TUCKER

CASE NUMBER 14-0189SI

HELD IN THE US FEDERAL COURTHOUSE

ON MAY 20, 2014 AT 3:35 P.M.

MCALESTER, OKLAHOMA

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[89] [redacted] The second drug was fine, I think.

CAPTAIN CHRISTIAN: Okay.

[redacted] I think. Third drug is when we started to see something.

CAPTAIN CHRISTIAN: Issues? Okay.

[redacted] Yes, sir.

CAPTAIN CHRISTIAN: Walk us through that.

[redacted] Squirming in the bed.

CAPTAIN CHRISTIAN: He – Lockett?

[redacted] Yeah.

CAPTAIN CHRISTIAN: Okay.

[redacted] He mumbled something. I'm not too sure what he mumbled, but he did mumble something.

CAPTAIN CHRISTIAN: Okay. Explain his movement. Was his movement more passive-like or – I don't know what the exact word would be – or was it aggressive violent-type?

[redacted] Hmm. I think he was trying to get up out of the – out of the – and we had him strapped down and taped down and wouldn't let him. Arching his back.

CAPTAIN CHRISTIAN: Okay.

[90] [redacted] You know, I guess to an extent you could say it was aggressive. I guess. I mean, like I said we never used this stuff before so, you know, I – I don't know, I don't – he tried to get up. In my opinion he tried to get up, because it floored me. You know, after several times, Doc had a concerned look on [redacted] face, looking at the EKG, looking at the clock up here.

CAPTAIN CHRISTIAN: Uh-huh.

[redacted] Doc gets up. I can't remember if that was before the blinds were shut or after. I think it was before. Looks at him and said

there's a – I think it was a problem. Warden shut the blinds – or, no. They tried to work on him, I think, first and then they shut the blinds.

And what I was saying about the drugs, at some point Doc had taken that out at the – towards the end – towards the – after the blinds were shut. Doc had taken that IV line out so I told them to stop pushing. I mean we couldn't push it anywhere else.

CAPTAIN CHRISTIAN: Right.

[redacted] But they were still [91] pushing up until we were told, you know, until he took it out.

CAPTAIN CHRISTIAN: Okay.

[redacted] The IV line.

CAPTAIN CHRISTIAN: There was no communication from the executioner in the back room to stop pushing the drugs?

[redacted] Not at that point, no. Not at that point. You know, I'm looking out the window here. I didn't see any puddles or anything out of the ordinary that would indicate there was something wrong. You know.

CAPTAIN CHRISTIAN: Okay.

CAPTAIN TUCKER: Let me back up just a minute. So after he was declared unconscious you start – that's your signal when the Warden says he's unconscious –

[redacted] Yes, sir.

CAPTAIN TUCKER: – that's your signal to have the executioners start pushing the second?

[redacted] Second and third one, yes, sir.

CAPTAIN TUCKER: Second you'll – you'll do the first – syringe of the second

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[95] anything to do with – okay, start this. Now do this. That's the EMT's job to do that.

[redacted] No. Just – I –

CAPTAIN TUCKER: Next in line is –

[redacted] – my thing is, start.

CAPTAIN TUCKER: Okay.

[redacted] And then five minutes, flip the light and then with this particular thing, when we had the different checks – just like I said, the phenobarbital, it's usually done, and you're done with this one. We wait the two minutes, he was finally unconscious and start – then start the next one.

CAPTAIN TUCKER: When did you see him start to move between what series of drugs? Do you know, or was this during the pushing of the second and third drug?

[redacted] It was the third drug in between the – during the third drug for sure, but I

couldn't tell you if it was during the second at all, I can't remember. But I know the third drug for sure. I don't know if it was in between or during the second. I can't remember that.

[96] CAPTAIN TUCKER: Okay. Okay. Go ahead.

[redacted] Like I said then the Doc come over here to the side that the IV was inserted in the groin area and there was no kind of puddling – you know, people saying it leaked out – or if it did it went in the body. I don't know I'm not the doctor so I wouldn't know. But there was nothing on the floor or anything like that. But you were asking before if all of them went in – if all of the drugs went in. There was probably a little bit left in one of the two of them when we stopped. I mean we – you know, if they would have found another vein we would have kept going. But that – that was – there was a little bit. I couldn't tell you how much.

CAPTAIN CHRISTIAN: On the third one?

[redacted] On the third one, yes, sir.

CAPTAIN CHRISTIAN: So the EMT is responsible for handing over each one of these syringes to each executioner every time they need them? One's a drug, then one's a saline,

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[99] actually stop pushing the drugs?

[redacted] When [redacted] took that line out. We all already knew –

CAPTAIN TUCKER: You visually saw [redacted]?

[redacted] Yes, sir. Uh-huh. Yes, sir.

CAPTAIN TUCKER: Okay.

CAPTAIN CHRISTIAN: Okay. So you were still – even though the curtains were dropped, you guys were still pushing drugs until [redacted] pulled the IV?

[redacted] Yes, sir.

CAPTAIN CHRISTIAN: Okay.

[redacted] Yes, sir.

CAPTAIN CHRISTIAN: So she – she – no one ever gave you – I'm assuming the Warden – Warden Trammell, but nobody gave you guys any instructions to stop after the curtains were dropped. They just – what were they doing in the execution room – while you guys are still pushing drugs and the curtain's coming down, what's –

[redacted] They were checking him and they were on the phone and –

CAPTAIN CHRISTIAN: But at that point

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[108] CAPTAIN TUCKER: [redacted] you said when the – when you saw the doctor remove the

IV or the line from the – the IV from the line, did you verbally tell the executioner, hold what you're doing [redacted](inaudible).

[redacted] I – stop.

CAPTAIN TUCKER: Stop.

[redacted] Uh-huh, And [redacted] did. Yeah.

CAPTAIN TUCKER: And they did?

[redacted] Yes, sir.

CAPTAIN TUCKER: Is that when the EMT came out?

[redacted] Yeah. In a minute or two. You know, by the time we got rearranged in there and they come out, yeah.

CAPTAIN TUCKER: Okay. From – while you guys are in the back room, and I'm specifically speaking of the back room there – you, the executioners, and EMT, is there any comments or anything about – that you guys are in discussion – you guys are having about, like it was taking longer or do you guys communicated as a (inaudible)?

[redacted] No. The only thing –

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[131] signed.

CAPTAIN TUCKER: Okay. I want (inaudible).

[redacted] Because I was [redacted] that day, so I know.

CAPTAIN TUCKER: Okay. So just so I'm clear on this last comment you made.

The Attorney General's office rewrote your policy or your – your legal division did?

[redacted] I – I'm – I'm saying the Attorney General's office did.

CAPTAIN TUCKER: That's your opinion (inaudible)?

[redacted] Yes, sir. My opinion and – and I don't know for sure, but that's my opinion.

CAPTAIN TUCKER: And were you involved in this process of rewriting it or did they basically produce it to you and tell you to go get it signed?

[redacted] They –

CAPTAIN TUCKER: How did that process take place?

[redacted] As far as – I got a [132] phone call; the Warden needs to sign this and it was scanned, or whatever, to us and we went and got it signed. Or they called our procedures officer which writes the policies and told her what to put in it and she put it in and then had – let them review it. They said it was okay, and then we had it signed.

CAPTAIN TUCKER: So you had – did you take it over to the Warden or did a staff member?

[redacted] No. I had a staff member.

CAPTAIN TUCKER: And she signed it –

[redacted] I believe so.

CAPTAIN TUCKER: – and then what happened after that?

[redacted] It was sent back to them and that was – they said we're going to use.

CAPTAIN TUCKER: Okay.

[redacted] Because there's five different methods in that policy now.

CAPTAIN TUCKER: Yes. I read those.

[redacted] Yes, sir. And there didn't used to be. It was just was the phenobarbital.

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TRANSCRIPT OF RECORDED INTERVIEW
OF
JOHN HADDEN
BY
TROOPER MATT GOTTSCHALK
TROOPER DONALD KRAFT
CASE NUMBER 14-0189SI
ON MAY 15th, 2014, AT 9:39 A.M.

* * * * *

[2] **LEGEND:**

MR HADDEN: **JOHN HADDEN**

TROOPER GOTTSCHALK:
TROOPER MATT GOTTSCHALK

TROOPER KRAFT:
TROOPER DONALD KRAFT

==========

TROOPER GOTTSCHALK: Alright today's date is May 15th, 2014; time is 9:39 a.m. Present in the room is Trooper Donald Kraft and myself, Trooper Matt Gottschalk, spelling M-A-T-T, G-O-T-T-S-C-H-A-L-K. This is an interview with Mr. John Hadden. Mr. Hadden, if you could please state and spell your entire name for me please.

MR HADDEN: My name is John David Hadden. First name J-O-H-N, middle D-A-V-I-D, last H-A-D-D-E-N.

TROOPER KRAFT: Also Trooper Donald Kraft. D-O-N-A-L-D, last name is K-R-A-F-T.

TROOPER GOTTSCHALK: Okay, Mr. Hadden, are you aware that this interview is being recorded and may be reduced to a typed official record at a later time?

MR HADDEN: Yes, sir.

TROOPER GOTTSCHALK: Okay. This interview is being conducted pursuit to case, number 14-0189SI regarding the execution that took place at the Oklahoma State Penitentiary on April 29th, of 2014. Mr. Hadden, what's your current home address?

MR HADDEN: My current home address is [redacted]

TROOPER GOTTSCHALK: Okay.

MR HADDEN: Just as a point of clarification, it's a rental because my house was hit in the tornado last year so . . .

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[14] minutes they normally do a consciousness check so mean that'll give me an idea about where we're at. But it was going a little while and he was just – everyone in a while he sort of lick his lips like he was trying to regain focus or something so I'm thinking to myself well, he must be getting something because he's obviously exerting some effort to maintain consciousness. And I want to say it around four minutes, four and half minutes or so he closed his eyes and his

jaw went a little slack as if he was asleep or something. And then the person in the chair and that's when I decided [redacted] must have been a doctor because [redacted] went out and did some consciousness checks and if I recall, well I won't get into where I can recall because I can't really can't. But I recall that I knew that when they did conscious checks they generally did different kinds. They did several sort of increasing rates of conscious checks. So I kinda knew what [redacted] was doing [redacted] was – [redacted] started out saying his name or something and shaking him. And [redacted] did one where [redacted] struck his eyelash and then the last one was [redacted] took [redacted] knuckles and rubbed them on his rib cage pretty strongly. And so the first conscious check [redacted] said he's not unconscious and [redacted] sat back down. He didn't look to me lie he moved though. So I don't know how [redacted] determined that. I don't know if he said something to [redacted] or what. [redacted] back was blocking but I saw no movement.

TROOPER GOTTSCHALK: Okay.

MR HADDEN: And then [redacted] sat back down and when [redacted] sat down he still had his eyes closed and his mouth was open like it was before so I just thought well, you know, whatever, I guess we wait longer. So they waited two more minutes and then [redacted] did it again and at that point [redacted] said he's unconscious and so at that point the Warden said something like – I think she just said well he's unconscious and then I assume that was sort of the key to begin introduction of the remaining drugs. And to be honest with you at that point in time I thought he might be deceased

because there was no movement, breathing, there's no respiration. I mean it was stock still. And like I said his [15] mouth was still slack and his eyes were closed. So anyway, again we began waiting and I don't remember how long it was, probably a minute, he mumbled something or made some kind of sound. And it didn't sound like a word to me. It just sounded like a sound someone might make if you try to wake them out of a deep sleep or something, if you shook somebody on the couch and they were sleep or something.

TROOPER GOTTSCHALK: Um hmm.

MR HADDEN: And I just – I remember thinking to myself why that's curious that you might get that after such a long period of time of nothing but, you know, I'm no doctor. I don't know about these things so I sat still and continued waiting. And then at some point he kinda did it again but this time he kinda raised his head up a little bit and – but the whole time his eyes were closed. He never at any point that I saw ever opened his eyes. He kinda would as, you know, time would kinda go on it was almost like he was trying to get up.

TROOPER GOTTSCHALK: Um hmm.

MR HADDEN: And that's the best way I know how to describe it. It wasn't as if he was in my interpretation he was in pain where he was trying to, you know, I don't know get out of them or escape or anything like that. Like I said his eyes were never opened that I saw. And he would murmur things

occasionally but again they were unintelligible words to me. I could make nothing out of them and I was trying really hard because –

TROOPER GOTTSCHALK: Right.

MR HADDEN: We've had previous instances where people's said my body is burning and all kinds of things, so I was trying to listen for anything that sounded like an actual word and I couldn't make anything out.

TROOPER GOTTSCHALK: How was the sound quality coming into yawl's – into the room?

* * *

[18] MR HADDEN: Yes. Yes, I was out there with Bates and Mr. Bates and there were several, well I couldn't even tell you who they were. DOC officials out there. There were some security people and some other things.

TROOPER GOTTSCHALK: Okay.

MR HADDEN: And so at that point all of us sort of walked down the hall away from the direction they're gonna go and Bates had went around the corner but we all kinda just got out of the way because we we're like all these people are going to be coming out and everything. We just don't want to, you know, be trampled and everything so we went around the corner and we just kinda stayed there for a little bit and then a couple of minutes later the Director came around and said [redacted]

[redacted] And so we went back in and the Warden and the doctor were in there at that point and the Warden was, I don't know a good word, she just was a little – I don't want to say she was agitated or anything like that. She wasn't. She was just I wanna say a little distress. That's the probably best the [inaudible 27:44]. She wasn't crying or anything but she was visibly sort of shaken I guess is probably the best way to say it. And the doctor was standing there and [redacted] looked a little shaken too but [redacted] didn't seem, you know, appalled or anything as if, you know, oh my gosh, I can't believe this happened. And I recall the only thing [redacted] really said, the doctor said at that point was, you know, I've never experienced anything like that and [redacted] said something along the lines of I've never used this drug before [redacted] says I, I, I, I don't know what to say. And so at that point they said we could, I don't remember if they said we could ask questions or does anybody have any questions or whatever [19] and I just thought, you know, I may never see this doctor again. I don't even know [redacted] name. I've got to ask [redacted] a couple of questions so –

TROOPER GOTTSCHALK: Um hmm.

MR HADDEN: Even for my conscious or whatever, I've got to know

TROOPER GOTTSCHALK: Right.

MR HADDEN: Some answers. And so I pressed [redacted] pretty hard.

TROOPER GOTTSCHALK: Um hmm.

MR HADDEN: And I said is there any doubt in your mind whatsoever that he was unconscious when you said he's unconscious? [redacted] said no. No doubt whatsoever and there was no hesitation whatsoever in [redacted] voice. And I'm certainly no expert on people and emotions. I've questioned a lot of people over the years and [redacted] had no reservations or hesitations so in my mind whatever medical knowledge [redacted] had [redacted] applied it and [redacted] was happy with [redacted] determination. And then I asked [redacted] is there any doubt in your mind that he was – that he felt any pain after you called – determined he was unconscious? And [redacted] said, no. He felt no pain whatsoever. That's what [redacted] said to me. So I just thought those were the two things I was most concerned with. Beyond that I guess everything else would get sorted out as it does. So that was really kind of the end of it. We just kinda at that point – everyone kinda went back to their vehicles and we went back towards the main house and Tom had his cell phone with him. He received special allowance to bring it in. Unfortunately he had no reception in the H-Unit area cause it's like a bunker, so as soon as he gets out his phone is of course exploding. Everyone's calling him and he's talking to, you know, I don't even know, just people calling him non-stop and him calling people non-stop.

And we went around and then we walked over to the area where the victim's families were and he went in and spoke with the victim's families for a little bit and I waited outside.

TROOPER GOTTSCHALK: Um hmm.

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TRANSCRIPT OF RECORDED INTERVIEW

OF

PARAMEDIC/EMERGENCY
MEDICAL TECHNICIAN

BY

CAPTAIN JASON HOLT

AND

CAPTAIN PAUL CHRISTIAN

CASE NUMBER 14-0189SI

HELD IN THE TROOP Z HEADQUARTERS

ON MAY 23, 2014, AT 5:10 P.M.

IN OKLAHOMA CITY, OKLAHOMA

* * * * *

* * *

[20] did not read anything.

CAPTAIN HOLT: Okay.

EMT: During the process of getting him ready for the – to the IV stick, he was very cooperative and I had asked him – I said are you a drug user? Were you a drug user?

And he said yes.

And I said are you right handed?

And he said yes.

I said okay. Your left arm is going to be the scarred one; right?

And he said if you will go right above the scars, I have a good vein. He said but I have been dehydrating myself for the last three days.

And I said, well, that makes it a little hard for me to make a stick.

And he said yeah.

And that was it.

CAPTAIN HOLT: So he – he made that statement to you?

EMT: Yes, he did.

CAPTAIN HOLT: Okay. Did you make any observations that would confirm that he had been dehydrating himself for that long, that

* * *

[85] CAPTAIN HOLT: – before I forget, and if I don't ask you now I'm might. What do you mean by you don't think you had enough drugs? Just because you didn't have as much this time as what you've had in the past?

EMT: Yeah. Basically. Versed, I use it to sedate people when I'm intubating and putting the tube down their throat so they can breathe in the field. Well –

CAPTAIN HOLT: That's the first drug you're talking about?

EMT: Do What?

CAPTAIN HOLT: The first drug is – did you say –

EMT: The first drug.

CAPTAIN HOLT: Okay.

EMT: See I use that in the field in ambulance work. And you do .5 milliliter and that – that's a paralytic and it paralyzes them so I can get the – the tube in and the half-life of that is just – like ten minutes. And so they come back awake real easy, if you don't continue the drip or whatever. And I just don't – 40 should have done the trick and it may very well be the trick. But [86] because the IV had infiltrated or blown or got dislodged or whatever the case may be, it didn't work.

CAPTAIN HOLT: Okay,

EMT: Have you heard anything back on the autopsy –

CAPTAIN HOLT: No.

EMT: – as to what happened on that?

CAPTAIN HOLT: It's still – still going.

EMT: I would be really interested to find that out.

CAPTAIN HOLT: It's still going. It'll probably still be several weeks before – before we actually get that back from Dallas.

EMT: Yeah. In of course, it's – all I'm doing is speculating, But –

CAPTAIN HOLT: Uh-huh, I understood. I understand that. At what – at what point of the – while you're doing drugs 2 and 3, at what point is the execution stopped?

EMT: Well, we had the last syringe of drugs. There was 10 milliliters left in it that I – that I wasted. And I was taking

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TRANSCRIPT OF RECORDED INTERVIEW
OF
PHYSICIAN
BY
CAPTAIN JASON HOLT
TROOPER KEVIN LOGAN
CASE NUMBER 14-0189SI
ON MAY 27TH, 2014, AT 05:31 P.M.

* * * * *

* * *

[16] [redacted] you know, to sedate a person,

CAPTAIN HOLT: Was anything ever said by yourself, the paramedic or any of the D.O.C. staff regarding what their plans would have been if you couldn't start any vein?

DOCTOR: No, I didn't know what they were going to do.

CAPTAIN HOLT: Okay. So you never heard that mentioned by anybody?

DOCTOR: No.

CAPTAIN HOLT: Follow-up?

TROOPER LOGAN: Yeah, I may and I got just a few questions and I may kind of jump around a little bit.

DOCTOR: Sure.

TROOPER LOGAN: Did you ever hear anybody – this is after you noticed that there's a problem, the warden closes the blind,

DOCTOR: Mm-hmm.

TROOPER LOGAN: Do you ever hear anybody say to stop the execution?

DOCTOR: No

TROOPER LOGAN: Okay, I think Jason kind of asked this, but, kind of looking at a little different time frame here. As you talked to the warden and you tell her there is a problem, how specifically do you do that? I mean, know you get up out of your chair, but do you walk up to her . . .

DOCTOR: I walked up to her and said, "there's something wrong," and I looked, that's when I pulled the sheet and looked, and told her, I said, "This is infiltrated." I said, "You're not getting," you know, "The medications aren't getting into the vein properly,"

TROOPER LOGAN: Okay. And they closed the shade?

DOCTOR: Right.

TROOPER LOGAN: And then at some point there, there's a lapse and she asked about lifesaving measures?

DOCTOR: Yes. She said, "Can you resuscitate him?" I think, I think it was the warden, I'm pretty sure it was, and I said, "do you want me to try?" I said, you know, "I, I'll try," but then I said, "But then we are going to have to take him to the ER." Then [17] somebody in the room said, "No we can't do that."

TROOPER LOGAN: So between that point and the time that you pronounce him, do you know about how much time has lapsed there?

DOCTOR: I want to say five or ten minutes. Like I said it was, I probably waited several minutes longer. Like I said he went into an agonal rhythm and just, just a thready pulse, but I wasn't willing to, to declare him at that point. He was unconscious, he was unresponsive, like I said. They weren't going to resuscitate him, so, I waited until he went into asystole and then I declared him.

TROOPER LOGAN: So going back to the femoral line, if you were in the hospital setting, you placed that in, would you typically look up and make sure you have a drip coming out of the bag?

DOCTOR: Yeah. We'll watch and see if you got a flow.

TROOPER LOGAN: Okay.

DOCTOR: Okay, and then you can watch the area around the catheter and you see if, you know, if you're starting to get edema underneath the skin which means it, you know, some of the fluid is

coming back up, you know, under the skin instead of going all directly into the vein.

TROOPER LOGAN: And in this case, do you ever see the bag, do you ever see the drip?

DOCTOR: Yeah we, like I said, initially [redacted] had bent the, the catheter, they had a problem [redacted] had to reposition it and then it started flowing.

TROOPER LOGAN: Okay,

DOCTOR: Yeah.

TROOPER LOGAN: So you visually saw that and saw that (unintelligible)?

DOCTOR: And you have to keep, you have to remember something, he got enough medication to make him unconscious. I mean, so, the medication was getting into there, a certain amount of it, at what point it stopped, don't know.

TROOPER LOGAN: Sure.

DOCTOR: But he had enough to make him unconscious and enough to actually to complete the execution.

TROOPER LOGAN: Sure.

* * *

* * * * *

TRANSCRIPT OF RECORDED INTERVIEW
OF
PHYSICIAN
BY
CAPTAIN JASON HOLT
TROOPER KEVIN LOGAN
CASE NUMBER 14-0189SI
ON MAY 27th, 2014, AT 6:18 P.M.

* * * * *

* * *

[4] TROOPER LOGAN: Did that ever take place?

DOCTOR: Yes.

TROOPER LOGAN: And that would be on the, so you get up one time, check him.

DOCTOR: Check him, he, he was not completely. He, he was, he still had a little bit of a response. So I said he is not. Sat back down. Tried it, waited a few more minutes and checked him and he didn't have any response.

TROOPER LOGAN: Did you guys go over or talk about any kind of protocol within the execution room, if there was any problems . . .

DOCTOR: No.

TROOPER LOGAN: That you would be aware of.

DOCTOR: No.

TROOPER LOGAN: And how that would take place.

DOCTOR: No.

TROOPER LOGAN: Okay. You mentioned before, I think you called it, excuse me if I get it wrong, Verset, Versed.

DOCTOR: Mm-hmm.

TROOPER LOGAN: Also known as . .

DOCTOR: Midazolam.

TROOPER LOGAN: Okay. You, you mentioned that Lockett didn't get enough of it, that enough of it didn't go in. What did you mean by that?

DOCTOR: No, I said, apparently. It's, it's a sedative hypnotic, okay. But it is also an anticonvulsant, so if he had enough of that medication in him, I wouldn't expect him to have any type of seizure activity.

TROOPER LOGAN: Okay.

DOCTOR: Okay. And they, I think they said they were going to give him like 20 mg. If that's the case, you know he shouldn't, he shouldn't have had any type of activity.

TROOPER LOGAN: So the movements that you saw, as you described . . .

DOCTOR: Shouldn't have, like I said

TROOPER LOGAN: Or seizures, so . . .

[5] DOCTOR: Like I said, if those were, and I think they were, okay. Then I don't think he got enough of the, of the Versed in him. It was enough to render him unconscious, temporarily, but then when the other medications were infused, and the other, and the You have to remember, Versed is a fairly short acting medication too, so it starts wearing off fairly quickly.

TROOPER LOGAN: So you say short, what's, I mean, short to me may be a different . . .

DOCTOR: It depends on the individual, 20, 30 minutes, It's, it can start wearing off very quickly, yeah.

TROOPER LOGAN: Okay. And that's.

DOCTOR: So that

TROOPER LOGAN: That's about.

DOCTOR: That's peak activity. Pardon?

TROOPER LOGAN: When you say 20 to 30 minutes, on how much dosage?

DOCTOR: Oh well, I mean if I give a person enough, obviously he is going to, you know. It depends on the person's metabolism first of all, okay.

Now if I give them enough to slow their metabolism, metabolism down, and slow their heart rate down, then they're not, you know, then it isn't going to wear off. But if he gets just a small amount, and his metabolism is working properly. You know, he is going to start, you know, he is going to start coming out of it, like I said in 20 to 30 minutes.

TROOPER LOGAN: Okay, So talking about the movements of, of Lockett, since we are talking about that briefly here, can you tell me about from the, when the execution starts, you had mentioned you could see when the first drug was pushed, because, because you could see

DOCTOR: I could see it flowing.

TROOPER LOGAN: Pushing,

DOCTOR: Right

TROOPER LOGAN: Through the line . . .

DOCTOR: Yeah, I was watching it to see if it was flowing,

TROOPER LOGAN: So when that starts, when you, when you see that,

* * *

No. 14-7955

IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

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QUESTIONS PRESENTED

1. Is it constitutionally permissible for a state to carry out an execution using a three-drug protocol where:

(a) there is a well-established scientific consensus that the first drug has no pain relieving properties and cannot reliably produce deep, coma-like unconsciousness, and

(b) it is undisputed that there is a substantial, constitutionally unacceptable risk of pain and suffering from the administration of the second and third drugs when a prisoner is conscious?

2. Does the *Baze*-plurality stay standard apply when states are not using a protocol substantially similar to the one that this Court considered in *Baze*?

3. Must a prisoner establish the availability of an alternative drug formula even if the state's lethal-injection protocol, as properly administered, will violate the Eighth Amendment?

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

Pursuant to Supreme Court Rule 24.1(b), the following list identifies all of the parties before the United States Court of Appeals for the Tenth Circuit.

Charles F. Warner, Richard E. Glossip, John M. Grant, and Benjamin R. Cole, by and through his next friend Robert S. Jackson, were appellants below. These appellants collectively petitioned this Court for a writ of certiorari. Petitioner Charles F. Warner was executed by the State of Oklahoma on January 15, 2015, after the decision below and before this Court granted the petition. Appellants Glossip, Grant, and Cole are petitioners here.

Kevin J. Gross, Michael W. Roach, Steve Burrage, Gene Haynes, Frank "Frazier" Henke, Linda K. Neal, Earnest D. Ware, Robert C. Patton, and Anita K. Trammell were appellees below and are respondents here. Respondents are all employees or agents of the Oklahoma Department of Corrections. All respondents are sued in their official capacities only.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED	1
INTRODUCTION	2
STATEMENT OF THE CASE	3
I. BACKGROUND	3
II. PROCEDURAL HISTORY	22
SUMMARY OF ARGUMENT	25
ARGUMENT	28
I. THE EIGHTH AMENDMENT PROHIBITS EXECUTIONS USING INDISPUTABLY PAINFUL DRUGS UNLESS THEY ARE PRECEDED BY ADMINISTRATION OF A MEDICALLY RELIABLE GENERAL ANESTHETIC.	28
A. The Undisputed Facts Alone Establish The Objectively Intolerable Risk Of Harm Posed By Using Midazolam As The Sole Anesthetic In An Otherwise Painful Lethal-Injection Protocol.	28

TABLE OF CONTENTS—continued

Page

B. The District Court Erroneously Credited Unreliable Expert Testimony Regarding Midazolam's Suitability In A Three-Drug Protocol. 32

II. THE COURT SHOULD CLARIFY THAT PRISONERS ARE ENTITLED TO A STAY UPON A SHOWING OF A SIGNIFICANT POSSIBILITY OF SUCCESS ON THE MERITS. 39

III. CONDEMNED PRISONERS NEED NOT PLEAD ALTERNATIVES TO AVOID AN UNCONSTITUTIONALLY CRUEL EXECUTION 46

CONCLUSION 53

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Texas: State Bought Execution Drugs From a Compounding Pharmacy, N.Y. Times, Oct. 3, 2013..... 47

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OPINIONS BELOW

The order of the United States District Court for the Western District of Oklahoma denying relief is reported at 2014 WL 7671680 (W.D. Okla. Dec. 22, 2014), J.A. vol. I 41-42 [hereinafter J.A.].

The opinion of the United States Court of Appeals for the Tenth Circuit denying relief is reported at 776 F.3d 721 (10th Cir. 2015), J.A. 111-39.

This Court's grant of a stay of petitioners' executions pending disposition of this case or Oklahoma's selection of a constitutionally permissible lethal-injection protocol is reported at 2015 WL 341655 (2015), J.A. 140.

JURISDICTION

The court of appeals issued its decision affirming the district court's denial of a preliminary injunction on January 12, 2015. The petition for certiorari was filed on January 13, 2015. This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Eighth Amendment to the United States Constitution provides in relevant part that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const. amend. VIII.

Title 42, section 1983, of the United States Code states that "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction

thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . ." 42 U.S.C. § 1983.

INTRODUCTION

Oklahoma intends to execute petitioners by injecting them with large amounts of a paralytic drug and potassium chloride. The paralytic drug produces a chemical entombment, paralyzing and eventually suffocating the person. Potassium chloride feels like liquid fire as it courses through the veins; it eventually stops the heart. Throughout this process, the paralytic drug ensures that observers see no evidence of suffering, because the prisoner will be completely paralyzed.

It is constitutionally intolerable to use these drugs to execute any prisoner still capable of sensing pain. These drugs cause not merely death, but also agonizing pain and suffering. Such a method of execution violates the Eighth Amendment's prohibition against cruel and unusual punishment. The Framers placed off limits such means of execution as burning a prisoner. From the perspective of causing intolerable pain and suffering, injecting a prisoner with liquid fire is just as unconstitutional as lighting him afire.

The administration of painful drugs is constitutional only if the prisoner is first placed in a deep, comalike state of unconsciousness, comparable to the anesthesia that precedes an otherwise painful surgery. For a quarter century, lethal injections using painful drugs have begun with the administration of barbiturates—either sodium thiopental or pentobarbital—which reliably induce and maintain a comalike state that renders a person insensate to pain. When

properly administered, barbiturates eliminate the risk that a prisoner will feel pain from the administration of other lethal drugs.

The State of Oklahoma now intends to use the anti-anxiety drug midazolam (sold under the trade name Versed) rather than a barbiturate, as the sole drug to anesthetize prisoners. Midazolam, however, is not approved or used as a standalone anesthetic during painful surgeries, because it is inherently incapable of reliably inducing and maintaining deep, comalike unconsciousness. The substitution of midazolam for barbiturates creates an objectively intolerable risk that prisoners will experience excruciating pain and suffering during their executions.

The Tenth Circuit upheld Oklahoma's use of midazolam based on a misunderstanding of this Court's decision in *Baze* v. *Rees*, 553 U.S. 35 (2008), and of petitioners' claim. Unlike in *Baze*, petitioners are not seeking procedures to avoid human error in carrying out an otherwise constitutional method of lethal injection. Petitioners instead are challenging a method of lethal injection that, even if carried out as written, will be cruel and unusual. That method violates the Eighth Amendment.

STATEMENT OF THE CASE

I. BACKGROUND

1. In the lethal-injection formula approved in *Baze*, "[t]he first drug, sodium thiopental (also known as Pentothol), is a fast-acting barbiturate sedative that induces a deep, comalike unconsciousness when given in the amounts used for lethal injection." *Baze*, 553 U.S. at 44. "The second drug, pancuronium bromide (also known as Pavulon), is a paralytic agent that inhibits all muscular-skeletal movements and,

by paralyzing the diaphragm, stops respiration." *Id.* "Potassium chloride, the third drug, interferes with the electrical signals that stimulate the contractions of the heart, inducing cardiac arrest." *Id.*

The Court recognized that the second and third drugs in this lethal-injection formula would cause objectively intolerable pain and suffering in a person who is not in a comalike state. The Court thus acknowledged that, "failing a proper dose of sodium thiopental that would render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride." *Id.* at 53. Consequently, whether the injection of the paralytic[1] and potassium chloride as a method of execution passes constitutional scrutiny depends on whether the state adopts a reliable means for first rendering the prisoner deeply unconscious, and thus "ensures that the prisoner does not experience any pain associated with the paralysis and cardiac arrest caused by the second and third drugs." *Id.* at 44. Because sodium thiopental does reliably produce a "deep, comalike unconsciousness," *id.*, and because Kentucky's procedures included "safeguards" for properly administering the formula, the Court concluded that there were not "objectively intolerable" risks of maladministration. *Id.* at 62. Ap-

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[1] This brief uses "paralytic" to refer to pancuronium bromide, vecuronium bromide, and rocuronium bromide. All agree that these drugs are functionally equivalent insofar as each will produce paralysis and agonizing asphyxiation in an aware individual, who will be unable to communicate his terror, pain, and suffering. It also was undisputed that potassium chloride will produce burning and intense pain as it circulates through the body. Answer to Amended Complaint at ¶ 50, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Nov. 14, 2014), ECF No. 96; *see* J.A. 341; *see also* J.A. 218-19.

plying these standards, this Court upheld Kentucky's three-drug protocol.

2. In the context of lethal injection, there is no medical dispute that sodium thiopental, if effectively administered, will reliably produce "deep, comalike unconsciousness." *Baze*, 553 U.S. at 44. All parties in *Baze* conceded that sodium thiopental had that property. *Id.* The Court's recognition of sodium thiopental's capabilities is also supported by its accepted medical use "as the sole anesthetic agent for brief (15 minute) procedures." DailyMed, *Thiopental Sodium*, Label Archives (Feb. 7, 2011), https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=48745;[2] see also J.A. 296-97. As the anesthesiologist who testified below explained, a large dose of sodium thiopental will cause a "barbiturate coma." J.A. 207.[3] A patient in such a coma will not sense the pain and suffering caused by the paralytic or potassium chloride, or the pain of an invasive surgical procedure. See, *e.g.*, J.A. 206-07, 226.

At the time of *Baze*, sodium thiopental was manufactured domestically by Hospira, Inc. In 2010,

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[2] The product label is the "most objective and complete information that we have about a drug and its legal use within the United States." J.A. 259. Any "indications and usage[s]" endorsed by the label "means that the manufacturer . . . has submitted clinical trials that have been reviewed by FDA scientists that show that the drug actually does what the manufacturer says that it will do." J.A. 261; J.A. 259; *see Mut. Pharm. Co.* v. *Bartlett*, 133 S. Ct. 2466, 2471 (2013).

[3] A coma is a state of profound unconsciousness from which one cannot be roused, even by powerful, noxious stimulation. *Stedman's Medical Dictionary* 414 (28th ed. 2006); *Dorland's Illustrated Medical Dictionary* 358 (28th ed. 1994).

Hospira developed regulatory and supply difficulties.[4] Hospira then intended to transfer its thiopental-manufacturing business to a new facility in Italy. See Alan M. Wolf, *Hospira Halts Rocky Mount Production of Death Penalty Drug*, N. Observer (Raleigh, N.C.), Jan. 21, 2011. Owing to this shortage, several states imported sodium thiopental from unregistered foreign sources. See *Cook* v. *FDA*, 733 F.3d 1, 4 (D.C. Cir. 2013). The Court of Appeals for the District of Columbia later held that those imports violated federal law. *Id.* at 10-11. Subsequently, in 2011, Hospira decided to exit the U.S. market entirely, explaining that the company was not confident that it could comply with Italy's laws relating to capital punishment. See Press Release, Hospira, Inc., Hospira Statement Regarding Pentothal™ (sodium thiopental) Market Exit (Jan. 21, 2011), *available at* http://phx.corporateir.net/phoenix.zhtml?c=175550&p=irol-newsArticle&ID=1518610&highlight.

Thereafter, several states, including Oklahoma, chose to replace sodium thiopental with another barbiturate, pentobarbital.[5] Pentobarbital, like sodium

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[4] *See, e.g.*, Warning Letter from John R. Gridley, Dir. Atl. Dist., FDA, to Christopher B. Begley, CEO, Hospira Inc. (Apr. 12, 2010), *available at* http://www.fda.gov/ICECI/EnforcementActions/WarningLetters/2010/ucm208691.htm (describing manufacturing violations at Hospira's facility at Rocky Mount, North Carolina); Am. Soc'y of Health-System Pharmacists, *Thiopental Injection*, Discontinued Drug Bulletins (Jan. 21, 2011), http://www.ashp.org/menu/DrugShortages/DrugsNoLongerAvailable/Bulletin.aspx?id=563 (noting issues with raw-materials supplier).

[5] Several states abandoned the three-drug approach in favor of a one-drug method using an overdose of a single barbiturate—essentially the method the petitioners in *Baze* had proposed. *See, e.g.*, *Towery* v. *Brewer*, 672 F.3d 650, 657 (9th Cir. 2012) (Arizona); *Pavatt* v. *Jones*, 627 F.3d 1336, 1337 n.1 (10th Cir.

thiopental and other barbiturates, is "capable of producing . . [a] deep coma." DailyMed, *Label: Nembutal Sodium*, http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5c380ab0-4386-48b6-80ab-ca594b23bc74 (last update May 2012). It is also commonly used for non-human animal euthanasia. See *Baze*, 553 U.S. at 58. Courts upheld Oklahoma's (and other states') use of pentobarbital as a replacement for sodium thiopental because "the use of pentobarbital to induce a barbiturate coma, which . . . is a common use of pentobarbital, takes the patient to a state of unconsciousness beyond a normal clinical level of anesthesia." *Pavatt*, 627 F.3d 1337, 1339 (10th Cir. 2010).[6] From December 2010 to January 2014, Oklahoma carried out seventeen executions using pentobarbital as the first drug in its three-drug protocol. J.A. 153; Justin Juozapavicius, *Oklahoma Will Not Review Protocol After Recent Executions*, NewsOK.com, Jan. 28, 2014, http://newsok.com/oklahoma-will-not-review-protocol-after-recent-executions/article/3927866/?page=1.

Meanwhile, in July 2011, the manufacturer of pentobarbital, Lundbeck, placed distribution controls on

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2010) (Washington); *Cooey* v. *Strickland*, 589 F.3d 210, 215 (6th Cir. 2009) (Ohio).

[6] *See DeYoung* v. *Owens*, 646 F.3d 1319 (11th Cir. 2011) (upholding as constitutional Georgia's use of pentobarbital as the first drug in three-drug protocol); *Powell* v. *Thomas*, 641 F.3d 1255 (11th Cir. 2011) (same regarding Alabama); *Beaty* v. *Brewer*, 649 F.3d 1071 (9th Cir. 2011) (same regarding Arizona); *Jackson* v. *Danberg*, 656 F.3d 157 (3rd Cir. 2011) (same regarding Delaware); *Valle* v. *Singer*, 655 F.3d 1223 (11th Cir. 2011) (same regarding Florida); *Rhoades* v. *Reinke*, 671 F.3d 856, 860 n.1 (9th Cir. 2011) (same regarding Idaho); *Beaty* v. *Brewer*, 791 F. Supp. 2d 678, 683 (D. Ariz. 2011) ("[P]entobarbital has been used either singularly or as a substitute for sodium thiopental in executions in Mississippi, Ohio, South Carolina, and Texas.").

the drug to prevent what it deemed the "misuse" of its products in executions.[7] Lundbeck's corporate decision gradually reduced the supply of pentobarbital to prisons, and states began seeking pentobarbital from other sources.[8] Some states considered different drug combinations.[9] And still others, including Oklahoma, Florida, and Alabama, retained a three-drug protocol, but chose midazolam as the first drug. See J.A. 51; *Muhammad* v. *State*, 132 So.3d 176, 188 (Fla. 2013) (noting Florida switched to midazolam in three-drug protocol in October 2013); *Arthur* v. *Thomas*,

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[7] *See* Press Release, Lundbeck, Lundbeck Overhauls Pentobarbital Distribution Program to Restrict Misuse (July 1, 2011), *available at* http://investor.lundbeck.com/releasedetail.cfm?ReleaseID=605775.

[8] *See, e.g.*, *Wellons* v. *Commissioner, Ga. Dep't of Corr.*, 754 F.3d 1260, 1262 (11th Cir.) (per curiam) (suggesting that Georgia is using compounded pentobarbital), *cert. denied sub nom. Wellons* v. *Owens*, 134 S. Ct. 2838 (2014); *In re Lombardi*, 741 F.3d 888, 891 (8th Cir.) (Missouri using compounded pentobarbital), *cert. denied sub nom. Zink* v. *Lombardi*, 134 S. Ct. 1790 (2014); *Chester* v. *Wetzel*, No. 1:08-cv-1261, 2012 WL 5439054, at *7 (M.D. Pa. Nov. 6, 2012) (Pennsylvania using compounded pentobarbital); *Whitaker* v. *Livingston*, 732 F.3d 465, 468 (5th Cir.) (per curiam) (Texas using compounded pentobarbital), *cert. denied sub nom. Yowell* v. *Livingston*, 134 S. Ct. 417 (2013).

[9] In January 2014, Ohio used midazolam in combination with hydromorphone to carry out an execution. *See In re Ohio Execution Protocol Litig.*, 994 F. Supp. 2d 906, 913 (S.D. Ohio 2014). The execution was not without incident. *See infra* at p. 20-21. In July 2014, Arizona used the same combination of drugs as Ohio, and it resulted in a nearly two-hour execution. *See* Order, *Wood* v. *Ryan*, No. 2:14-cv-01447-NVW (D. Ariz. July 24, 2014), ECF No. 34. Executions are currently stayed in both Ohio and Arizona. *See* Press Release, Ohio Dep't of Rehabilitation & Corr., Execution Dates Revised (Jan. 30, 2015), *available at* http://www.drc.ohio.gov/Public/press/press437.htm; Order, *Wood*, No. 2:14-cv-01447-NVW (D. Ariz. Nov. 24, 2014), ECF No. 68.

No. 2:11-cv-438-WKW, 2015 WL 224738, at *1 n.1 (M.D. Ala. Jan. 15, 2015) (noting Alabama switched to midazolam in September 2014).

3. Oklahoma's current lethal-injection protocol, effective September 30, 2014, was developed by the Oklahoma Department of Corrections. Pls.' Ex. 68, *Warner*, No. 5:14-cv-665 (OSP Execution Procedures OSP-040301 (Sept. 30, 2014))[10] Under the protocol, there are four different drug formulas[11]—two of which use midazolam—and the Director of the Department of Corrections has the sole discretion to choose which one is to be used. See *id.* at 36-38.

On March 17, 2014, days before the scheduled execution of Clayton Lockett and Charles Warner, Pls.' Ex. 13, *Warner*, No. 5:14-cv-665 (Order Setting Execution Date, *Warner* v. *State*, Okla. Crim. App., Case No. D-2003-829 (Jan. 23, 2014)); Pls.' Ex. 14, *Warner*, No. 5:14-cv-665 (Order Setting Execution Date, *Warner* v. *State*, Okla. Crim. App., Case No. D-2000-1330); the Oklahoma Attorney General announced that his usual source of pentobarbital "fell through," and he had not found it elsewhere. Pls.' Ex. 15 at 8, *Warner*, No. 5:14-cv-665 (Supp. Br. of Appellee State of Oklahoma, *Lockett* v. *State*, Okla. Crim. App., Case Nos. D-2000-1330 & D-2003-829 (Mar. 17, 2014)).[12]

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[10] Under Oklahoma law, lethal injection is the default method of execution. *See* 22 Okla. Stat. Ann. § 1014(A) (2011).

[11] The options are: a one-drug method using pentobarbital; a one-drug method using sodium thiopental; a two-drug method combining midazolam and hydromorphone; or a three-drug method with midazolam followed by a paralytic and then potassium chloride.

[12] Oklahoma's usual pentobarbital source is not clear, but an investigation uncovered emails between Oklahoma officials joking in 2011 that Oklahoma would reveal to Texas officials how

Rather than seeking to postpone the scheduled executions, the Attorney General set out to find alternative drugs that were immediately available on the open market. Pls.' Ex. 15 at 9, *Warner*, No. 5:14-cv-665; see also J.A. 148; J.A. vol. II 4-6.

On March 21, only four days after announcing difficulty in obtaining pentobarbital,[13] the respondents chose midazolam as a replacement for pentobarbital in the three-drug protocol, retaining the paralytic and potassium chloride.[14] J.A. 145; J.A. vol. II 29; J.A. vol. II 31. Oklahoma's selection of midazolam was grounded in expedience, rather than science.

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to deal with the sodium thiopental shortage in return for 50-yard-line tickets for "Team Pentobarbital" to the Oklahoma-Texas football game. *See* Katie Fretland, *Records Show Oklahoma Officials Wanted Perks for Helping Texas in Search for Scarce Lethal Injections*, Colo. Indep. (Mar. 18, 2014), http://www.coloradoindependent.com/146553/oklahoma-scrambles-to-find-lethal-injections-for-two-imminent-executions.

[13] As the State was unable to find a replacement before Lockett's scheduled execution, the executions of both Lockett and Warner were eventually reset for April 29. Pls.' Ex. 16 at 3, *Warner*, No. 5:14-cv-665 (Order Vacating & Resetting Execution Dates, *Lockett* v. *State*, Okla. Crim. App. Case Nos. D-2000-1330 & D-2003-829 (Mar. 18, 2014)); Exec. Order No. 2014-08, Governor of Oklahoma (Apr. 22, 2014), *available at* https://www.sos.ok.gov/documents/executive/939.pdf).

[14] The State attempted to buy compounded midazolam and compounded pancuronium bromide before ultimately purchasing manufactured midazolam and vecuronium bromide. *See* Pls.' Ex. 1, *Warner*, No. 5:14-cv-665 (Letter to Madeline Cohen & O. Dean Sanderford from Assistant Attorney General John Hadden (Apr. 11, 2014)); Pls.' Ex. 8, *Warner*, No. 5:14-cv-665 (Letter to Madeline Cohen & O. Dean Sanderford from Assistant Attorney General John Hadden (Apr. 4, 2014)); Pls.' Ex. 17, *Warner*, No. 5:14-cv-665 (Letter to John Hadden from Madeline Cohen & O. Dean Sanderford (Apr. 10, 2014)).

Based upon anecdotes from other states and internet postings, including "Wiki leaks or whatever it is," lawyers for the State concluded—incorrectly—that "midazolam had the same properties as pentobarbital as far as sedation goes." J.A. vol. II 7; J.A. 145; J.A. 149. No State officials responsible for selecting midazolam consulted with any experts, doctors, or scientists. J.A. vol. II 4; Tr. of Prelim. Inj. Hr'g at 300, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) [hereinafter Tr.]; J.A. 157. Rather, respondents claimed that midazolam would survive constitutional scrutiny "because a court in Florida found it constitutional." Tr. 508. The State moved with haste to ensure that then-scheduled executions would go forward, acknowledging that "[i]f either pentobarbital or sodium thiopental were available, Director Patton[, one of the respondents here,] would have selected them rather than the midazolam protocols." J.A. 79; J.A. 147; J.A. 164.

But Florida's use of midazolam as the first drug in a three-drug protocol does not establish that midazolam is effective at maintaining deep unconsciousness. By preventing movement, the paralytic masks a prisoner's suffering if he returns to consciousness from the pain of the paralytic and potassium chloride. See J.A. 333 (testimony of respondents' expert). Thus, midazolam's shortcomings—and a prisoner's suffering—may be discernible only in an execution where the administration of the paralytic was interrupted. See *Warner* v. *Gross*, 135 S. Ct. 824, 826-27 (2015) (Sotomayor, J., dissenting) (discussing problems with Oklahoma's execution of Clayton Lockett).

4. Midazolam belongs to a class of drugs called benzodiazepines. J.A. 286; J.A. 171; J.A. 204-05; J.A. 260-61; J.A. 341; Tr. 661. Benzodiazepines include drugs such as Valium, Ativan, and Xanax; midazolam

is the shortest acting of the class. J.A. 171. Benzodiazepines, including midazolam, are used for their anti-anxiety, anti-seizure, sedative, and muscle-relaxant properties. They are prescribed to treat anxiety disorders and insomnia, to reduce anxiety before general anesthesia, and for conscious sedation for minor outpatient procedures. J.A. 241, J.A. 287-88; J.A. 171. Midazolam is approved for use "for preoperative sedation/anxiolysis/amnesia," J.A. 287; see also J.A. 203, and is mainly used prior to medical procedures to calm a patient. J.A. 171; J.A. 203. Most importantly, midazolam is not approved for—and, in fact, is not used as—the sole anesthetic during a painful procedure. Tr. 145; J.A. 206.

To explain the properties of midazolam and its use in medical settings and in Oklahoma's execution procedures, petitioners presented expert testimony from David Lubarsky, M.D., a practicing anesthesiologist and Chairman of the Department of Anesthesiology at the University of Miami, Miller School of Medicine, J.A. 200; Eric D. Katz, M.D., a practicing emergency medicine physician and Chairman of the Department of Emergency Medicine at the University of Arizona College of Medicine, J.A. 337-38; and Larry Sasich, Pharm. D., a consulting pharmacist with ten years of experience as a research analyst, and sixteen years of experience as a clinical professor, J.A. 257-58. Respondents chose to present testimony from Roswell L. Evans, Pharm. D., a dean at the school of pharmacy at Auburn University whose scholarship in the past twenty years addresses pharmacy education, teaching, and economics. J.A. 305-06; Defs.' Ex. 34 at 6718-22, *Warner*, No. 5:14-cv-665 (Dec. 17-19, 2014) (Curriculum Vitae of R. Lee Evans). Evans's scholarship in pharmacology is limited, and he has not published a clinical study of drug effects since approximately

1997. Defs.' Ex. 34 at 6718-22, *Warner*, No. 5:14-cv-665.

a. All experts agreed that midazolam is neither approved by FDA for use as, nor used as, the sole drug to maintain general anesthesia during a painful procedure. Tr. 145; J.A. 203 ("[S]urgeons can] do a full operation with a barbiturate. You cannot do that with midazolam."); J.A. 223 ("[Midazolam] would never be used and has never been used as the sole anesthetic to give anesthesia during a surgery. Not ever."); J.A. 327; see also J.A. 76; J.A. 204. The experts also agreed that midazolam has no analgesic (or pain-relieving) qualities. J.A. 204-05; J.A. 261; J.A. 341; J.A. 310-11; Tr. 661; see also J.A. 76. Accordingly, respondents' expert testified that if physicians wanted to use midazolam "as the sole anesthetic agent in a painful procedure," he would "advise them not to do that." J.A. 332-33.

Midazolam's inability to serve reliably as the sole anesthetic for a painful procedure was established in clinical trials, where patients who were "given midazolam in doses sufficient to produce unconsciousness d[id] not tolerate the noxious stimuli of surgery." Tr. 143; see also J.A. 219 (petitioners' expert explaining that midazolam "was not approved by the FDA as a sole anesthetic because after the use of fairly large doses that were sufficient to reach the ceiling effect and produce induction of unconsciousness, the patients responded to the surgery"). The studies show that although midazolam can cause unconsciousness and unresponsiveness to minor stimuli, a person rendered unconscious by midazolam is not in a comalike state, and can be "jolted into consciousness" by the infliction of pain. J.A. 230-31; see J.G. Reves et al., *Midazolam: Pharmacology and Uses, Anesthesiology* 62:310 at 318 (1985) ("Midazolam cannot be used

alone, however, to maintain adequate anesthesia. . . .").[15]

b. Petitioners' experts also explained why midazolam cannot reliably serve as general anesthesia, and why barbiturates can. Barbiturates and benzodiazepines are different classes of drugs that work "via different mechanisms" and "in different strength." J.A. 172, 206, 207. Barbiturates do not have a "ceiling effect," and can quiet all brain activity and cause a coma in a way that midazolam cannot. J.A. 206-07; Robert K. Stoelting & Simon C. Hillier, *Pharmacology & Physiology in Anesthetic Practice* 141 (4th ed. 2005) ("Midazolam, in contrast to barbiturates and propofol, is unable to produce an isoelectric EEG [a coma].").

Midazolam facilitates the binding of gamma-aminobutyric acid (GABA) to GABA receptors in the brain. J.A. 172, 206-07. GABA is a naturally occurring substance within the body that serves to inhibit brain activity. J.A. 232; J.A. 206. GABA inhibits the

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[15] The experts further agreed that clinical doses of midazolam can cause a "paradoxical reaction," where a person experiences "agitation, combativeness, and anxiety as a result of the administration of the drug." J.A. 210; *see also* J.A. 263; Tr. 669. The FDA-approved product labeling warns of paradoxical reactions, *see* J.A. 290; J.A. 263-64; Tr. 349, which are more likely to occur in people—like petitioners—with "behaviors such as aggression, impulsivity, substance abuse, and suffering from other psychiatric disorders or psychological disturbances." Tr. 116; *see* Pls.' Ex. 81 at 2-3, *Warner*, No. 5:14-cv-665 (Aff. of Donna Schwartz-Watts, *Grant* v. *Workman*, N.D. Okla., Case No. CIV-05-167-TCK); Pls.' Ex. 82 at 4, 24-31, *Warner*, No. 5:14-cv-665 (Indep. Psychiatric Consultation re Benjamin Cole – Report conducted by Raphael Morris, M.D., in *Cole* v. *Workman*, Case No. CIV-08-328-CVE); Pls.' Ex. 83 at 4-5, *Warner*, No. 5:14-cv-665 (Decl. of Ruben C. Gur, Ph.D. in *Cole* v. *Workman*, Case No. CIV-08-328-C); Pls.' Ex. 84, *Warner*, No. 5:14-cv-665 122 (Okla. Dep't of Corr. Mental Health Record, Richard Glossip).

flow of electrical impulses through the neurons in the brain. When GABA binds to a receptor on a neuron, it makes it "much harder for a neuron in the brain to send along an electrical impulse." J.A. 207. The effect of GABA is useful to healthy brain functioning, for example preventing seizures. But at an extreme, when enough neurons in the brain stop firing, a person will no longer feel sensation or process thoughts. J.A. 206.

Barbiturates, including pentobarbital and sodium thiopental, also facilitate the activity of GABA to inhibit neurons. J.A. 207; J.A. 172; J.A. 232. But barbiturates have an additional, direct effect on GABA receptors that midazolam does not have. Barbiturates bind directly to receptors, mimicking the action of GABA. Stoelting & Hillier, *supra*, at 128. Thus, even if all the naturally occurring GABA has been bound, barbiturates will bind to additional GABA receptors and inhibit more and more neurons from firing. A large amount of barbiturates will silence brain activity and create a coma. J.A. 206.

Unlike barbiturates, midazolam does not mimic GABA, bind to receptors, and stop neurons from firing electrical impulses on its own; midazolam needs GABA to affect brain activity. J.A. 172. Thus, midazolam's effect is effectively capped by the limited amount of GABA in the brain. J.A. 172; J.A. 206, 208-09. Once all GABA has been bound, increasing the dose of midazolam does not suppress additional brain activity. J.A. 205-06. This is midazolam's "ceiling effect," a fundamental and unavoidable pharmacological property shared by all benzodiazepines, which

clinical studies in rats and in humans have demonstrated. J.A. 265; J.A. 209.[16]

In other words, although "people normally assume that, well, if you give twice as much of the drug you would get twice that effect[,] [t]hat's not the case with midazolam." J.A. 205-06.[17] Instead, unlike barbiturates, midazolam's effect is capped ultimately by the body's own production of GABA. J.A. 205-06. Because barbiturates can mimic GABA and bind to GABA receptors, their administration has no comparable ceiling effect. J.A. 208-09; J.A. 226.

Given midazolam's ceiling effect, and its poor performance as the sole anesthesia in clinical trials, midazolam cannot reliably provide the deep, comalike state necessary to avoid responsiveness to pain. See Tr. 145 (Dr. Lubarsky's opinion is "based on what we

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[16] *See* Stoelting & Hillier, *supra*, at 141 ("[B]enzodiazepines have a built-in ceiling effect that prevents them from exceeding the physiologic maximum of GABA inhibition. The low toxicity of the benzodiazepines and their corresponding clinical safety is attributed to this limitation of their effect on GABAergic neurotransmission.").

[17] The fact that midazolam has a ceiling effect was acknowledged by all experts and established below. J.A. 206; Tr. 343; Tr. 664. Although respondents' distinguished this effect as something that occurs only on "the spinal cord" and not "in the brain," J.A. 78; Tr. 664; J.A. 311-12, that statement misapprehends basic physiology—midazolam's ceiling effect occurs because of the body's finite supply of GABA, which is not limited to the spinal cord. When GABA is exhausted, midazolam has no further effect. *See* Stoelting & Hillier, *supra*, at 141; Steven C. Curry et al., *Neurotransmitters*, *Goldfrank's Toxicology Emergencies* 155 (6th ed. 1998) ("In general, GABA inhibition predominates in the brain. In the spinal cord, through mono- and polysynaptic reflex pathways, GABA mediates a number of physiologically minor peripheral effects outside the CNS (*e.g.*, vasodilation, bladder relaxation).").

know about mechanisms of action, how it works, where it binds, that it has a ceiling effect, that it has been studied in both humans and rats and deemed insufficient for surgical anesthesia in any dose form by the FDA").

c. Notwithstanding the above evidence, respondent's expert opined that 500 milligrams of midazolam would induce and maintain comalike unconsciousness in a person during the period between its administration and death. J.A. 327-28; Tr. 666. He based his conclusion on two linked conjectures.

First, respondents' expert presumed that a "toxic" dose of midazolam would cause a sustained coma before it caused death. Tr. 661. He admitted, however, that "there are no studies that have been done and probably could be done" to corroborate the supposition that a "toxic reaction" to midazolam would cause a sustained coma before causing death. J.A. 327. He could cite no data, studies, or reports establishing that a toxic administration of midazolam ever has caused—much less reliably would cause—a sustained coma rendering a person insensate to pain. *Id.* He instead testified that he simply "extrapolat[ed]" from his understanding of how midazolam could cause deaths to assume that, at some point before death, a coma would occur. *Id.*

Second, respondents' expert opined that 500 milligrams of midazolam would be a sufficiently "toxic" dose to cause death within thirty minutes and, in some non-specified but associated way, a coma. *Id.*; J.A. 332. Dean Evans arrived at this opinion through unidentified sources[18] and mathematical error. To de-

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[18] Respondents' expert stated that there have been 80 reports of deaths "from the use of midazolam . as of 2009." J.A. 294; J.A. 309. He lacked any authority for the proposition and was

termine a "toxic" dose, Evans consulted "drugs.com"—which has a disclaimer that it is "not intended for medical advice, diagnosis or treatment," J.A. 275-76; J.A. 259; J.A. 303; Tr. 364-65—but was unable to point to data regarding a toxic dose on that site. J.A. 329-31.[19] He also cited a Material Safety Data Sheet ("MSDS") about midazolam. J.A. 294. The Occupational Safety and Health Administration ("OSHA") requires chemical manufacturers to post an MSDS to alert workers and downstream users about the potential hazards of handling a given chemical, see 29 C.F.R. § 1910.1200(g), and the MSDS warns that its data should not be relied upon "regarding its correctness." Defs.' Ex. 34 at 6560, *Warner*, No. 5:14-cv-665 (Dean Evans's Expert Report). This MSDS does not purport to define a clinically lethal dose, see Tr. 656, but only the amount of midazolam reported to be "toxic." Defs.' Ex. 34 at 6558, *Warner*, No. 5:14-cv-665 (reporting "TD_{LO} man, intravenous = 71 mg/kg"). It does not state whether or how often "toxic" doses resulted in death, or whether any dose created sustained comalike unconsciousness or pain suppression.

Moreover, in interpreting the MSDS, Evans admitted that he committed a basic mathematical error and underestimated the "toxic" dose for an average adult by a factor of one thousand. J.A. 329. Instead of the lowest "toxic" dose occurring at 0.071 mg/kg, as Evans originally opined, the number in the MSDS is

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"unclear" about the circumstances. *Id.* Dr. Lubarsky acknowledged "serious adverse events" with midazolam, but explained they occurred with "90-year-olds with congestive heart failure" and "rarely if ever" with "healthy individuals." J.A. 217.

[19] Petitioners' expert testified he would "not accept a work product from a student" if "drugs.com was used as the reference source." J.A. 259. *See* Tr. 337-38; J.A. 282-83.

71 mg/kg. J.A. 329. For a 70-kilogram adult, a "toxic" dose according to the MSDS thus would be 4,970 milligrams (that is, 71 mg times 70 kg), or ten times *more* than the 500-milligram dose Evans opined would cause coma and death.[20]

5. Oklahoma used midazolam for the first time in its execution of Clayton Lockett, on April 29, 2014. The State administered 100 milligrams of midazolam, and Lockett was declared unconscious seven minutes later. J.A. 53; Tr. 214-15; J.A. vol. II 46-48; Pls.' Ex. 93 at 4401, *Warner*, No. 5:14-cv-665. Lockett was then administered the paralytic and most of the potassium chloride. J.A. 53; Tr. 170. During the administration of the second and third drugs, however, Lockett awoke. J.A. 215-16, 345, 339. He began to writhe against the gurney, buck his head, and said "this shit is f[---]ing with my mind," "something is wrong," and "the drugs aren't working." J.A. 53; J.A. 350-51, 355-56; Tr. 181; Tr. 205; Tr. 219-20; Tr. 494. The viewing blinds that allowed witnesses to see into the execution chamber were then lowered. J.A. 56-57.[21] Twenty-four minutes later, Lockett died. J.A. 56.

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[20] Evans's unsupported assertion that 500 milligrams of midazolam reliably would be lethal and coma-causing formed the basis for his other opinions. Evans agreed that the ceiling effect exists, but testified that, "whatever the ceiling effect of midazolam may be with respect to anesthesia," it would be overcome by "a 500 milligram dose [which would] effectively paralyze the brain." J.A. 78. Evans also agreed that paradoxical reactions can occur, including after sedation, Tr. 670; *see also* J.A. 264; J.A. 244-45, but again opined—again without support—that a 500-milligram dose would prevent it. J.A. 315; Tr. 669.

[21] Witnesses were not fully able to observe Lockett's pain before the blinds were lowered, however, because Oklahoma had taped Lockett's hands into fixed positions and concealed his body under sheets, masking signs of distress. Pls.' Ex. 39 at

A state-commissioned report later concluded that a catheter failure caused the lethal drugs, at some point, to infiltrate Lockett's tissue instead of directly entering his bloodstream. J.A. 398; J.A. 51-52; Tr. 561-62. As a result, the second drug failed to effectively paralyze Lockett, allowing witnesses to see his return to consciousness and suffering, J.A. 53; J.A. 218 ("[The paralytic provides a] false sense of security and prevents people from seeing whether or not that surgical plane of anesthesia is still maintained.").

One hundred milligrams of midazolam did not place Lockett in deep, comalike unconsciousness before the paralytic and potassium chloride were administered.[22] Having been jolted into consciousness, Lockett "was surely experiencing all of the mental pain that is inevitable in the execution process as well as serious physical discomfort if not serious physical pain." J.A. 54. Moreover, midazolam provided no pain relief, Tr. 61-66; Tr. 352-55, as it is not pharmacologically capable of doing so. J.A. 204-05; J.A. 260-61; J.A. 310; Tr. 661. Lockett was "awake and struggling against the effects and the pain of the other drugs." J.A. 214.

Midazolam's inability to cause a deep comalike unconsciousness also was seen during executions in Ohio and Arizona. Each State has executed a prisoner using a mixture of midazolam and

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1619, *Warner*, No. 5:14-cv-665 (DPS Interviews of Paramedic (May 28, 2014; July 31, 2014)); Tr. 50.

[22] The IV failure would not have significantly impacted midazolam's effectiveness, because midazolam—unlike the paralytic—has a rapid absorption rate, even if not administered intravenously. J.A. 173; Tr. 116; J.A. 246-47; Tr. 352.

hydromorphone.[23] In January 2014, Ohio used 10 milligrams of midazolam and 40 milligrams of hydromorphone to execute Dennis McGuire, who gasped for nearly ten minutes before his death. See Alan Johnson, *Execution; State Will Increase Lethal Dosages*, Columbus Dispatch, Apr. 29, 2014, at 1B. In July 2014, Arizona used far more of each drug—750 milligrams of midazolam and 750 milligrams of hydromorphone—to execute Joseph Wood, and yet he gasped for nearly two hours before dying. See Fernanda Santos, *Executed Arizona Inmate Got 15 Times Standard Dose, Lawyers Say*, N.Y. Times, Aug. 2, 2014, at A11. Dr. Lubarsky testified below that the execution of Wood amounted to "unintentional experimental proof that large doses of midazolam do not necessarily kill you, [nor do they] guarantee unconsciousness, and that the administration of additional doses do not cause further depression of consciousness[.] [Otherwise,] Mr. Wood would have stopped breathing and would have gone into a coma were such large doses actually effective." J.A. 220. Wood's execution demonstrated the ceiling effect of midazolam and showed "that the 100 or 500 [milligrams] that might be used in Oklahoma now is not reliably going to be effective to produce the desired effect of a deeply unconscious state that is maintained at a surgical plane of anesthesia." J.A. 230; see also J.A. 176-77.

Notwithstanding midazolam's ceiling effect and the executions of Lockett, McGuire, and Wood, Oklahoma retains its midazolam-based, three-drug protocol. J.A. 158. On January 15, 2015, Oklahoma executed Charles Warner using the same formula used with

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[23] Hydromorphone is a narcotic opioid, sold under the trade name Dilaudid. J.A. 61; J.A. 297.

Lockett, albeit with a higher dose of midazolam. After he was injected with midazolam, but before he was sedated past the point of speech, Warner's last words were reported to have been "my body is on fire." Sean Murphy, *Dying Oklahoma Inmate's Last Words Stir Questions*, Associated Press, Jan. 16, 2015, *available at* http://www.nytimes.com/aponline/2015/01/16/us/ap-us-oklahoma-execution-lawsuit.html. Further information about Warner's execution currently is not available to petitioners, because, in response to discovery requests, Oklahoma has refused to provide evidence about Warner's execution.

II. PROCEDURAL HISTORY

1. On June 25, 2014, petitioners and other death-row prisoners sued respondents under 42 U.S.C. § 1983 in the United States District Court for the Western District of Oklahoma, challenging the State's execution method. Complaint, *Warner*, No. 5:14-cv-665 (June 25, 2014), ECF No. 1. Petitioners amended their complaint on October 31, 2014. Amended Complaint, *Warner*, No. 5:14-cv-665 (Oct. 31, 2014), ECF No. 75. On November 10, 2014, petitioners and then-plaintiff Charles Warner moved for a preliminary injunction to enjoin respondents from carrying out executions in an unconstitutional manner, including through the use of midazolam in a three-drug protocol. Motion for Preliminary Injunction, *Warner*, No. 5:14-cv-665 (Nov. 10, 2014), ECF No. 92.

Following an expedited one-month period for discovery, Scheduling Order re: Preliminary Injunction, *Warner*, No. 5:14-cv-665 (Nov. 6, 2014), ECF No. 88, on December 17-19, the district court held a three-day evidentiary hearing on the preliminary-injunction motion. The court ruled that "parties' experts will be allowed to rebut opposing experts'

reports and otherwise critique each other during their testimony," but the court's schedule did not permit petitioners to present rebuttal witnesses after the State's expert testified. Minute Order, *Warner*, No. 5:14-cv-665 (Dec. 15, 2014), ECF No. 162.

The parties' experts agreed that midazolam has no analgesic (or pain-relieving) qualities, J.A. 204-05, 260-61, and that midazolam is never used as "sole agent for general anesthesia," J.A. 204, 223, 262, 332-33, 340-41; Tr. 661. As described above, the experts diverged on whether 500 milligrams of midazolam would promptly and reliably produce a "deep, comalike unconsciousness" that would render a person insensate to severe pain.

2. On Monday, December 22, the district court ruled from the bench, denying relief.

a. The court found that midazolam has no analgesic properties, that it is not used or approved for anesthesia, and that it is approved for use as a sedative only "*before* administration of other anesthetic agents." J.A. 76 (emphasis added).

The court further found that midazolam increases the risk that a prisoner would feel pain, and that he "will not have the ability to express the fact that he senses pain" during the administration of the second and third drugs. J.A. 79. The court also found that "it is not likely that midazolam would be the [respondents'] first choice." J.A. 86; see also J.A. 79.

Relying solely on respondents' expert's testimony, the district court determined that 500 milligrams of midazolam "would make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs." J.A. 77. The court asserted, without explana-

tion, that there was "no need to dwell on the fact that [Evans] misplaced a decimal point in one of his observations about the possible lethal effect of midazolam." J.A. 75. The court similarly found persuasive Evans's opinions that the "guaranteed" toxicity of a 500-milligram dose minimized the "risks" of the ceiling effect and paradoxical reaction. J.A. 75, 78. The court found that midazolam had the capacity to cause "*a phenomenon which is not anesthesia* but does have the effect of shutting down respiration and eliminating the individual's awareness of pain." J.A. 78 (emphasis added).

b. The district court construed *Baze* to require petitioners to provide a "known and available" alternative method of execution in order to challenge the use of midazolam here. J.A. 97. Because petitioners failed to show that sodium thiopental was, in fact, commercially available to respondents, the court denied relief. J.A. 99. The court rejected petitioners' argument that, because injecting painful execution drugs after providing a prisoner only with midazolam is inherently a cruel punishment that violates the Eighth Amendment, this aspect of *Baze* is inapplicable. J.A. 89. Instead, it found that *Baze* was "speaking broadly" when it required prisoners to demonstrate an alternative, and that this requirement applies to any Eighth Amendment challenge to any method of execution. J.A. 89-90. Petitioners appealed. Notice of Appeal, *Warner*, No. 5:14-cv-665 (Dec. 23, 2014), ECF No. 176.

3. On January 12, 2015, without hearing argument, the United States Court of Appeals for the Tenth Circuit affirmed the denial of preliminary injunctive relief, adopting wholesale the district court's opinion. J.A. 139. The court of appeals held that the errors in respondents' expert testimony "were not suf-

ficiently serious to render [it] unreliable." J.A. 126; see also 134.

The court of appeals construed *Baze* to require proof of a "demonstrated risk of severe pain," finding it irrelevant that Oklahoma's protocol differs fundamentally from the one in *Baze*. The court of appeals held that *Baze* applies to "all challenges to 'a State's chosen procedure for carrying out a sentence of death.'" J.A. 131. The court of appeals further held that the Tenth Circuit's prior constructions of *Baze* required petitioners to show a known and available alternative to the method of execution at issue to obtain relief. J.A. 129-30 (citing *Pavatt*, 627 F.3d at 1339).

4. On January 13, 2015, petitioners, and Mr. Warner, filed a petition for writ of certiorari along with an application to stay their scheduled executions (No. 14A761). On January 15, 2015, this Court denied the stay application, and Mr. Warner was executed that evening. Justice Sotomayor, joined by Justices Ginsburg, Breyer, and Kagan, dissented from denial of the stay. *Warner*, 135 S. Ct. 824 (Sotomayor, J., dissenting). On January 23, 2015, this Court granted certiorari. On January 28, 2015, this Court granted respondents' application for stays of the then-pending scheduled executions of petitioners. J.A. 140.

SUMMARY OF ARGUMENT

I. The Eighth Amendment prohibits a method of execution that, like Oklahoma's, creates a "substantial risk of serious harm," or an "objectively intolerable risk of harm." *Baze*, 553 U.S. at 50. A protocol using painful lethal drugs is unconstitutional unless the prisoner is first properly administered a drug that reliably ensures a "deep, comalike unconsciousness"

throughout the execution. *Id.* at 44, 53. Midazolam cannot serve that purpose.

A. In *Baze*, there was consensus that sodium thiopental, if properly administered, would produce deep comalike unconsciousness. With midazolam, the opposite is true. Midazolam is not approved for use as the sole anesthetic for painful surgery. Clinical studies showed that midazolam does not reliably induce deep unconsciousness; when used in surgery, patients felt pain. The medical consensus is that midazolam cannot generate deep, comalike unconsciousness. There is also no substantial practice among the states of using midazolam for lethal injections. Although sodium thiopental was widely used for years, only four states have used midazolam in an execution, and only two have tried to use it as anesthesia. On these undisputed facts, the use of midazolam to create deep comalike unconsciousness presents an "objectively intolerable risk of harm." *Baze*, 553 U.S. at 50.

B. Whether a particular method of execution creates a constitutionally unacceptable risk of harm is a question of law subject to de novo review. But the district court's decision to credit the conjecture of respondents' expert that a 500-milligram dose of midazolam would create "a phenomenon that is not anesthesia" was, in any event, clear error. Midazolam's pharmacological properties, including its ceiling effect, mean that it cannot create deep comalike unconsciousness. Relying, as the district court did, on an undocumented "phenomenom" that concededly "is not anesthesia" itself creates an objectively intolerable risk of harm. Respondents' expert supported his opinion with reference only to undisclosed or unreliable sources and mathematical error. His unsupported supposition about how midazolam works in the body and brain has no acceptance within the scientific

community. Although the undisputed facts alone warrant reversal, the district court clearly erred in finding that respondents' expert testimony was reliable. *Anderson* v. *City of Bessemer City, N.C.*, 470 U.S. 564, 573 (1985); *Kumho Tire Co.* v. *Carmichael*, 526 U.S. 137, 149-50 (1999).

II. The Tenth Circuit and other courts have construed *Baze* to set a new and higher standard for obtaining a stay of execution in every Eighth Amendment challenge to a method of execution—one that effectively always forecloses a stay. That contravenes the plurality opinion in *Baze*—which did not cite, much less purport to overrule, the traditional standard for obtaining a stay of execution. *Hill* v. *McDonough*, 547 U.S. 573, 584 (2006) (requiring, *inter alia*, "a significant possibility of success on the merits"); *Barefoot* v. *Estelle*, 463 U.S. 880, 895 (1983) (same). If the Court did intend to create a new and higher stay standard, however, it should clarify that this heightened standard applies only to challenges "on grounds such as those asserted" in *Baze*, where a prisoner challenges a concededly humane method of execution and seeks to "show[] one more step the State could take as a failsafe for other, independently adequate measures." *Baze*, 553 U.S. at 61. Where prisoners do not concede that the State's method, if administered according to plan, would be constitutional, but instead challenge the method itself, then the traditional stay standard applies. *Hill*, 547 U.S. at 584.

III. The Tenth Circuit also erred in dismissing petitioners' claims based on the requirement that petitioners must propose a commercially available alternative drug for their executions. The Eighth Amendment places certain punishments beyond a state's power to carry out, and that prohibition does not van-

ish when a state determines that its preferred alternative is unavailable. The requirement that a prisoner must propose an alternative to avoid a cruel or unusual punishment is foreclosed by this Court's decision in *Hill* v. *McDonough*, 547 U.S. 573, which "unanimously rejected a proposal that . . . suits challenging a method of execution must identify an acceptable alternative." *Jones* v. *Bock*, 549 U.S. 199, 213 (2007) (construing *Hill*, 547 U.S. at 581-82), and which *Baze* did not overrule. The vitality of a core constitutional guarantee does not vary with the marketing decisions or supply constraints of private corporations.

ARGUMENT

I. THE EIGHTH AMENDMENT PROHIBITS EXECUTIONS USING INDISPUTABLY PAINFUL DRUGS UNLESS THEY ARE PRECEDED BY ADMINISTRATION OF A MEDICALLY RELIABLE GENERAL ANESTHETIC.

A. The Undisputed Facts Alone Establish The Objectively Intolerable Risk Of Harm Posed By Using Midazolam As The Sole Anesthetic In An Otherwise Painful Lethal-Injection Protocol.

In *Baze*, this Court grounded its acceptance of a three-drug protocol as a constitutional method of execution on the premise that the first drug in the protocol would "ensure" a "deep, comalike unconsciousness." 553 U.S. at 44. Where that level of unconsciousness is not reliably obtained, the Court recognized that there would be a "constitutionally unacceptable risk of suffocation . . . and pain" from the second and third drugs. *Id.* at 53.

The undisputed evidence here shows that midazolam cannot reliably ensure the "deep, comalike unconsciousness" required where a State intends to cause death with painful drugs. That midazolam has been tested and rejected for use as a sole anesthetic for surgery is sufficient alone to show a "substantial risk of serious harm" and an "objectively intolerable risk of harm" from the second and third drugs, thus establishing that Oklahoma's use of midazolam is "constitutionally unacceptable." *Baze*, 553 U.S. at 50, 53 (quoting *Farmer* v. *Brennan*, 511 U.S. 825, 846 & n.9 (1994)).

First, as in *Baze*, it is uncontested here that without appropriate anesthesia, the second and third drugs in Oklahoma's protocol cause the sort of "barbaric" pain and suffering—suffocation, paralysis, burning—that has always, since the Framing, been prohibited under the Eighth Amendment. See *In re Kemmler*, 136 U.S. 436, 446 (1890) (noting that the Eighth Amendment originally prohibited execution methods that "were manifestly cruel and unusual, [such] as burning at the stake, crucifixion, breaking on the wheel, or the like"). No one disputes that the second drug in Oklahoma's protocol "produce[s] paralysis and a slow death by asphyxiation" resulting in "terror, pain, and needless suffering." Amended Complaint at ¶ 98, *Warner*, No. 5:14-cv-665 (Oct. 31, 2014); Answer to Amended Complaint at ¶ 50, *Warner*, No. 5:14-cv-665 (Nov. 14, 2014), ECF No. 96; J.A. 214-15; J.A. 341; Tr. 351; Tr. 381. Nor does anyone contest that the third drug causes a person to feel "[e]xcruciating, searing, burning" pain. J.A. 215; Amended Complaint at ¶ 99, *Warner*, No. 5:14-cv-665; Answer to Amended Complaint at ¶ 50, *Warner*, No. 5:14-cv-665; J.A. 271; Tr. 353. Thus, the constitutionality of Oklahoma's protocol depends on whether

the first drug can reliably "ensure" a "deep, comalike unconsciousness." *Baze*, 553 U.S. at 44.

Second, the uncontested facts establish that the use of midazolam poses an objectively intolerable risk of severe suffering during the execution. In *Baze*, there was a medical consensus that sodium thiopental produces a "deep, comalike unconsciousness," and if properly administered, will be objectively certain to prevent subsequent pain. See, *e.g.*, 553 U.S. at 44. That consensus reflected the undisputed fact that sodium thiopental can be used as the sole anesthetic agent for otherwise intolerably painful surgery. See DailyMed, *Thiopental Sodium*, Label Archives (Feb. 7, 2011), https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=48745; see also J.A. 296; J.A. 206. It is further undisputed that the dose of sodium thiopental used for lethal injection reliably causes a "barbiturate coma," J.A. 207, where a prisoner could not sense the pain caused by other lethal drugs. See, *e.g.*, J.A. 206-07; J.A. 226.

There is no comparable medical consensus that midazolam is, or can be, reliably used to create a deep comalike unconsciousness. The medical consensus is, in fact, to the contrary. It is undisputed that midazolam is not approved for use, not recommended for use, and is not used, as the sole anesthetic during painful surgery. J.A. 223, 332-33, 341; see also Tr. 143 ("[P]atients who are given midazolam in doses sufficient to produce unconsciousness do not tolerate the noxious stimuli of surgery. We know that from when the drug was being studied and introduced."). All agree that "either in a clinical setting for inducing . . 'deep unconsciousness' or in a lethal-injection setting, midazolam is not the drug of choice." Tr. 689. Even the district court acknowledged that midazolam cannot be relied upon as "anesthesia." J.A. 78.

There also is no consensus among the States regarding midazolam's efficacy for use in capital punishment. Some states that once used or considered using midazolam have already abandoned it. See Brett Barrouquere, *Kentucky Drops 2-Drug Executions, Reworking Method*, Associated Press, Nov. 14, 2014, *available at* http://www.denverpost.com/ci_26937217/kentucky-drops-2-drug-executions-reworking-method; Mark Berman, *Ohio Drops Controversial Lethal Injection Drug, Postpones Upcoming Execution*, Wash. Post, Jan. 9, 2015, *available at* 2015 WLNR 790889. In fact, only four States have ever used midazolam in an execution,[24] and of those, only two—Oklahoma and Florida—have used it as the sole anesthetic for subsequent, painful drugs. J.A. 131-32. *Baze*, 553 U.S. at 53 ("[I]t is difficult to regard a practice as 'objectively intolerable' when it is in fact widely tolerated."); see also *id.* at 42 n.1, 51; *Kennedy* v. *Louisiana*, 554 U.S. 407, 421 (2008) (explaining that application of the Eighth Amendment turns, in part, on "'objective indicia of society's standards, as expressed in legislative enactments and state practice with respect to executions.'" (quoting *Roper* v. *Simmons*, 543 U.S. 551, 563 (2005)). Of the executions in which midazolam was administered, at least three (including Oklahoma's execution of Clayton Lockett) have triggered state investigations into why they did not go as planned. See, *e.g.*, J.A. 376-418; Fernanda Santos & John Schwartz, *A Prolonged Execution in Arizona Leads to a Temporary Halt*, N.Y. Times, July

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[24] *See Warner* v. *Gross*, 135 S. Ct. 824 (2015) (Sotomayor, J., dissenting) (Oklahoma); *Wood* v. *Ryan*, 759 F.3d 1076, 1078 (9th Cir.) (Arizona), *vacated*, 135 S. Ct. 21 (2014); *Chavez* v. *Florida SP Warden*, 742 F.3d 1267, 1270 (11th Cir.) (Florida), *cert. denied sub nom. Chavez* v. *Palmer*, 134 S. Ct. 1156 (2014); *In re Ohio Execution Protocol Litig.*, 994 F. Supp. 2d 906, 909 (S.D. Ohio 2014) (Ohio).

25, 2014, at A15; Alan Johnson, *Capital Punishment; Next Ohio Execution Postponed by Kasich*, Columbus Dispatch, Feb. 8, 2014, at 1B, *available at* http://www.dispatch.com/content/stories/local/2014/02/07/kasich-postpones-march-19-execution.html; cf. *Baze*, 553 U.S. at 46 (noting "no reported problems" in Kentucky's one pre-*Baze* lethal injection).

Together, these undisputed facts are more than sufficient to establish an "objectively intolerable risk" that a prisoner will suffer severe pain if midazolam is used as the sole agent to induce and maintain a deep comalike unconsciousness. If midazolam cannot reliably protect against the pain of surgery, it also cannot reliably protect against the agony of suffocation, paralysis, and "liquid fire." See *Baze*, 553 U.S. at 53 ("[T]here is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride."). On this basis alone, the judgment should be reversed.

B. The District Court Erroneously Credited Unreliable Expert Testimony Regarding Midazolam's Suitability In A Three-Drug Protocol.

Whether a particular method of execution creates an objectively intolerable risk of harm is, ultimately, a legal conclusion involving mixed questions of law and fact, and is therefore subject to de novo review. *Miller* v. *Fenton*, 474 U.S. 104, 116 (1985); *Bose Corp.* v. *Consumers Union of U.S.*, 466 U.S. 485, 510-11 (1984); see J.A. 78. Applying de novo review, the Court should hold that midazolam's pharmacological properties render it incapable of reliably inducing and maintaining deep comalike unconsciousness. But even if the district court's conclusion concerning mid-

azolam is reviewed for clear error, it cannot withstand review.

The district court found that midazolam will reliably create "a phenomenon that is not anesthesia," but that renders a person insensate to pain. J.A. 78. No scientific literature or method supports the district court's finding. For this reason as well, Oklahoma's proposed use of midazolam creates an objectively intolerable risk of harm.

The district court adopted the testimony of the sole expert respondents chose to present. This expert claimed, without scientific support, that the administration of 500 milligrams of midazolam would make it a "virtual certainty" that a prisoner would not feel pain from the administration of the second and third drugs. See J.A. 135 (quoting J.A. 77).

In crediting one expert's unsupported testimony, the district court committed clear error. See *Anderson*, 470 U.S. at 573 (quoting *United States* v. *U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948)) (holding that clear error occurs "when[,] although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed"); see also *United States* v. *Taylor*, 487 U.S. 326, 337 (1988). Courts are charged with "ensur[ing] the reliability and relevancy of expert testimony." *Kumho Tire Co.*, 526 U.S. at 152. "Proposed testimony must be supported by appropriate validation—*i.e.*, 'good grounds,' based on what is known." *Daubert* v. *Merrell Dow Pharma., Inc.*, 509 U.S. 579, 590 (1993). As this Court explained in *Kumho,* an expert's reliability may depend on many factors, including "[w]hether a 'theory or technique . . can be (and has been) tested;' [w]hether it 'has been subjected to peer review and publication;' [w]hether, in respect to a particular technique, there

is a high 'known or potential rate of error' . . and [w]hether the theory or technique enjoys 'general acceptance' within a 'relevant scientific community.'" 526 U.S. at 149-50 (quoting *Daubert*, 509 U.S. at 592-94).

This is not a case "where the evidence would support a conclusion either way." *United States* v. *Yellow Cab Co.*, 338 U.S. 338, 342 (1949). Nor is it a case where the district court "analyze[d] the evidence and show[ed] the reasons for the findings." *Id.* at 341; see J.A. 293. Rather, the court credited respondents' expert despite (1) his lack of any authority for his conclusion that a "toxic" dose of midazolam can be extrapolated to determine a dose that will cause a coma; (2) his admitted reliance on non-authoritative sources and mathematical errors in calculating the dose needed to cause death or induce a coma; and (3) his lack of any sources for his beliefs about how midazolam actually works in the human brain. While any one of those defects is reason enough to reject his testimony, respondents' expert's unsupported assumptions and mathematical mistakes, when "viewed in [their] entirety," plainly demonstrate that "a mistake has been committed" by the district court's acceptance of Evans's opinions as fact here. *Anderson*, 470 U.S. at 573-74 (citation omitted).

First, respondents' expert admitted that his crucial testimony that midazolam can cause a coma was based on "extrapolation" and "assumption," Tr. 667-68; he could not provide the sort of authority required for expert testimony to be credible or reliable. See *Kumho*, 526 U.S. at 149-50. Specifically, Dean Evans stated "[t]here's lots of literature to suggest that lower doses of the drug [midazolam] will cause death, so if we're *essentially extrapolating* this piece and *saying there is a linear effect* in terms of administration of

the drug and the concentrations you can receive centrally, then it makes sense, *it's a logical assumption to make in this case*." Tr. 667-68 (emphasis added). But simply "saying there is a linear effect" is not a reliable scientific method, especially when medical literature establishes that there is instead a ceiling effect, and when the expert supplies no authority to the contrary. Evans then built his "extrapolation" upon unsubstantiated anecdotes of deaths caused by unknown dosages of midazolam. Tr. 667-68. Those uncited anecdotes are probative (if at all) only to lethality—and even then, only in ill or elderly persons. See J.A. 217 ("[T]hose type of fatalities occur in 90-year-olds with congestive heart failure who have not had careful titration of the drug. It does not occur in otherwise healthy individuals in that range.").[25] The anecdotes do not address the crucial questions here, such as whether fatal midazolam overdoses are reliably preceded by a sustained comalike state and, if so, how long it takes midazolam to induce such a coma, and how long the victim remains insensate to pain. "Expert testimony which does not relate to any issue in the case is not relevant and, ergo, non-helpful." *Daubert*, 509 U.S. at 591 (citations omitted); see *Easley* v. *Cromartie*, 532 U.S. 234, 248 (2001).

Second, Dean Evans's assertion that a 500-milligram dose "absolutely" would ensure a coma, Tr. 661, was based on unreliable sources and an egregious mathematical error. Evans stated that he relied on two sources—the website "drugs.com" and one company's MSDS. Neither source "enjoys 'general acceptance' within a 'relevant scientific community.'" *Kumho*, 526 U.S. at 149-50 (citation omitted).

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[25] Evans failed to mention that what few fatalities involving midazolam exist are "often" reported "in combination with opioids." J.A. 281.

Drugs.com itself warns that it "is not intended for medical advice, diagnosis or treatment." J.A. 276; J.A. 303; see also J.A. 330; J.A. 325. An MSDS is simply an OSHA-mandated document that a company prepares to warn workers of potential dangers posed by the chemicals to which they are exposed. See 29 C.F.R. § 1910.1200(g)(1); Tr. 361—a fact that Evans did not even know, Tr. 656-57. By its own terms, "the information provided [in the MSDS is] without any warranty, express or implied, regarding its correctness." J.A. 279.

The numerical value Dean Evans purportedly derived from these sources also was critically flawed. As to drugs.com, when asked in court to locate the data on that site on which he relied, Evans could not do so. J.A. 330-31. As for the MSDS, Evans cited it for the proposition that a dose of midazolam, at 0.071 mg/kg of body weight, would cause death. J.A. 294; J.A. 327; Tr. 667-68. But Evans later admitted that he miscalculated the MSDS's dosage by a factor of one thousand, which renders Oklahoma's planned 500-milligram dose 10 times less than what, even if the MSDS is treated as a reliable source, would be a "toxic" amount for 70-kilogram person. J.A. 329; Defs.' Ex. 34 at 6558, *Warner*, No. 5:14-cv-665 (Dean Evans's Expert Report).

This remarkable error eliminates the basis for Dean Evans's "logical assumption" that Oklahoma's dosage of midazolam will cause death (much less cause a sustained coma, which is the relevant point). The magnitude of his mathematical error, and the simplicity with which it can be demonstrated, also undermine Evans's reliability as an expert for this subject. The district court stated there was "no need to dwell on the fact that [Evans] misplaced a decimal point in one of his observations about the possible le-

thal effect of midazolam." J.A. 75. That attempt to wish away an erroneous starting point for Evan's "extrapolation" stands alone as clear error, because once the decimal point is correctly placed, the toxicity numbers in the MSDS no longer support Evans's "extrapolation" to the conclusion that the 500-milligram dose of midazolam is necessarily lethal. Cf. *Kumho*, 526 U.S. at 151 ("[I]t will be appropriate for the trial judge to ask, for example, how often an engineering expert's experience-based methodology has produced erroneous results.").[26]

Third, much of Evans's opinions cannot be squared with basic medical facts.[27] For instance, it is a fact that midazolam works by potentiating GABA, allowing GABA to bind to GABA receptors more easily. *E.g.*, J.A. 171-72, 206-07, 232. It is also a fact that administering additional doses of midazolam, as with all benzodiazepines, will eventually lead to a "ceiling effect" once all of the brain's GABA is bound. J.A. 172, 206, 208-09; Tr. 343; Tr. 664; see, *supra* notes 16-17. Evans nonetheless testified that the ceiling effect is limited to the spinal column, and also that "[m]idazolam attaches to GABA receptors, inhibiting GABA." J.A. 311-12. Both points are wrong: the ceiling effect occurs due to the body's finite amount of

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[26] Evans's conclusion is all the more implausible given the executions of Clayton Lockett and Joseph Wood, where the prisoners remained alive despite having received dosages of midazolam that should have, under Evans's theory, put them into a coma and, in fact, killed them. J.A. 392-94; *see also* J.A. 176-77, 213-14, 220, 229-30, 233-34, 349-51; J.A. vol. II 47-48.

[27] Because the truncated schedule did not permit petitioners to call rebuttal witness to address the aspects of Evans's testimony that went beyond his expert report, petitioners provided the Tenth Circuit with an additional declaration and report regarding Evans's testimony. *See* J.A. 235-36; J.A. 283-84.

GABA that is available to bind to GABA receptors, in the brain and elsewhere; moreover, far from *inhibiting* GABA, midazolam *facilitates its binding* to GABA receptors (though it does not itself bind to those receptors in the way barbiturates do). Thus, it is not surprising that Evans could cite no pharmacological or medical literature for his novel, and patently incorrect, assertions. See *Kumho*, 526 U.S. at 149-50. For example, "[t]he spinal cord is not considered by any authoritative publication to be the primary site of anesthetic action, (Perouansky, Pearce & Hemmings, 2015)." J.A. 233.

In sum, the lower court's conclusion that it is a "virtual certainty" that a 500-milligram dose of midazolam will reliably "eliminat[e] an individual's awareness of pain" is based on an expert's unsupported "extrapolation" about a phenomenon other than anesthesia, derived from an incorrectly calculated "lethal" dose of midazolam. J.A. 77-78. That expert's explanation of how midazolam works in the human body was not based on medical authorities and, among other flaws, ignored stark examples of past executions in which high dosages of midazolam failed promptly to induce a coma—executions that instead triggered state investigations as to why the drug did not work as the state had expected. When the record is "viewed in its entirety," Evans's unsupported "extrapolation" makes it "[im]plausible" that his opinion is reliable. *Anderson*, 470 U.S. at 574. For this additional, independent reason, the Court should reverse the decisions below.

II. THE COURT SHOULD CLARIFY THAT PRISONERS ARE ENTITLED TO A STAY UPON A SHOWING OF A SIGNIFICANT POSSIBILITY OF SUCCESS ON THE MERITS.

The Eighth Amendment bars executions that cause "unnecessary cruelty" or a "lingering death." *Baze*, 553 U.S. at 48-49 (quoting *Wilkerson* v. *Utah*, 99 U.S. 130, 136 (1879) and *In re Kemmler*, 136 U.S. 436, 447 (1890)). With regard to cruelty, this Court has emphasized that it is "constitutionally unacceptable" for an execution to impose a "substantial risk of serious harm," or an "objectively intolerable risk of harm." *Baze*, 553 U.S. at 50, 53. Where, along with the other factors supporting a stay,[28] prisoners show "a significant possibility of success on the merits"—*e.g.*, that a method of punishment creates a "constitutionally unacceptable" risk of harm—they should be entitled to a stay of execution. *Hill*, 547 U.S. at 584; *Barefoot*, 463 U.S. at 895-96.

The Tenth Circuit construed *Baze* to set a new and higher standard for obtaining a stay in all Eighth Amendment cases—one that effectively forecloses a stay in all circumstances. Such a construction is at odds with the language and logic of *Baze*. If the Court did indeed intend to state a new and higher standard for a stay, it should clarify that this standard applies only "on grounds such as those asserted" in *Baze*, 553 U.S. at 61, and not to circumstances like those here.

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[28] In addition to a significant possibility of success on the merits, a petitioner seeking injunctive relief must also show that "he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter* v. *Natural Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). These other factors are not at issue—and are met—here.

The challenge in *Baze* arose from the risk of unintentional "maladministration of a concededly humane [execution] protocol." 553 U.S. at 41, 60-61. In explaining the standard for a stay for such a maladministration challenge, the plurality stated that "a *stay* of execution may not be granted *on grounds such as those asserted [t]here* unless the condemned prisoner establishes that the State's lethal-injection protocol creates *a demonstrated risk of severe pain*. [And, h]e must show that the risk is substantial when compared to the known and available alternatives." *Id.* at 61 (emphasis added). The plurality further stated that "[a] State with a lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard." *Id.*

The Tenth Circuit took this "demonstrated risk" language out of context in two ways. *First*, the Tenth Circuit misconstrued this language to have replaced the classic stay standard that has long governed Eighth Amendment claims with one that is much more demanding. See J.A. 130 (characterizing the "the demonstration of a risk of severe pain" as the "first requirement for a stay of execution"); see also *Wackerly* v. *Jones*, 398 F. App'x 360, 362 (10th Cir. 2010) ("*Baze* placed its substantive standard at the center of the stay analysis: '*A stay of execution may not be granted . . unless* the condemned prisoner establishes . . *a demonstrated risk of severe pain* . . .' " (citation omitted))

Second, the Tenth Circuit held that this heightened stay standard applies to "*all* challenges to 'a State's chosen procedure for carrying out a sentence of death,'" even where, as here (and unlike in *Baze*), a prisoner contends that the State's method, if carried out as intended, would *not* be humane. J.A. 131 (emphasis added) (quoting *Baze*, 553 U.S. at 48); see J.A.

131 ("*Baze*, as we read [it], w[as] not confined to claims of negligent administration of lethal injection protocols.").

Neither interpretation comports with *Baze*, which did not upset the classic requirements for staying an execution, and which expressly limited its application of those stay requirements to claims "such as those asserted [t]here," *i.e.*, those seeking to improve upon safeguards against the risk of maladministration of a concededly humane protocol. Where, as here, petitioners challenge a drug as inherently unsuited to act as a reliable anesthetic—and therefore challenge Oklahoma's ability to humanely carry out its chosen method of punishment—a petitioner seeking a stay of his objectively intolerable execution need only meet the traditional test for a stay that has always governed preliminary injunctions, *i.e.*, "a significant possibility of success on the merits," *Hill*, 547 U.S. at 584.

1. *Baze*'s use of the phrase "demonstrated risk" does not necessarily displace this Court's traditional standard for obtaining a stay of execution—*viz.*, "a significant possibility of success on the merits" and, *inter alia*, a likelihood of irreparable injury. *Hill*, 547 U.S. at 584. Demonstrating a likelihood of being able to show an objectively intolerable risk of pain is what one ordinarily would expect a prisoner to do to obtain a stay. None of the opinions in *Baze* cited *Barefoot* v. *Estelle*, 463 U.S. 880, the seminal case laying out the standard for a stay of execution, or *Hill* v. *McDonough*, 547 U.S. at 584, a more recent challenge to a lethal-injection protocol that resulted in a unanimous decision and a reaffirmation of *Barefoot*'s standard in method-of-execution challenges. The absence of any discussion in *Baze* about "the familiar standard for securing a stay" in a capital case, *Gray*

v. *Kelly*, 131 S. Ct. 2956, 2957 (2011) (referring to *Barefoot*), is a further indication that *Baze* did not alter the stay standard reaffirmed so recently in *Hill*. See *Shalala* v. *Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 18 (2000) ("This Court does not normally overturn, or so dramatically limit, earlier authority *sub silentio*.").

The unique claim in *Baze* confirms that *Baze* left the classic stay standard intact. In *Baze*, petitioners challenged a settled "method of execution believed to be the most humane" currently used. *Baze*, 553 U.S. at 53, 62; see also *id.* at 44 (noting 30 of 36 States "use[d] the same combination of three drugs"). If Kentucky's method was carried out correctly, petitioners conceded, it was certain that the method "will result in a painless death." *Id.* at 62. All agreed that the challenged method was chosen with an "earnest desire to provide for a progressively more humane manner of death" as compared to past methods. *Id.* at 51; see *id.* at 43 n.1 ("[T]he States were motivated by a desire to find a more humane alternative to then-existing methods."). There was no substantial evidence or scientific data supporting "a better method." *Id.* at 57.

The petitioners in *Baze* urged the adoption of an "untested alternative," one that petitioners "concede[d] ha[d] not been adopted by any State and ha[d] never been tried." *Id.* at 41, 51-52. Moreover, the risks they sought to avoid had never transpired—"extensive" factual proceedings failed to reveal even one "isolated mishap" or "reported problem[]" that had occurred in Kentucky using the challenged method. *Id.* at 46, 50.

That Eighth Amendment challenge was thus unlike any other the Court had previously confronted. In all prior method-of-execution cases, the allegation was

that the method itself—if carried out as intended—would inflict needless pain in violation of the Eighth Amendment. *E.g.*, *Louisiana ex rel. Francis* v. *Resweber*, 329 U.S. 459, 464 (1947); *Kemmler*, 136 U.S. at 443-44; *Wilkerson* v. *Utah*, 99 U.S. 130, 136 (1878). In *Baze*, however, no one challenged the propriety of the lethal-injection formula if properly administered. In fact, all agreed that science had progressed such that, barring human error in the administration of the drugs, it was certain that Kentucky's protocol could and would result in "a painless death." *Baze*, 553 U.S. at 62. It was assumed that, in the future, executions would become only "progressively more humane." *Id.* at 51, 62.

Given the expectation of steady "progress toward more humane methods of execution," *id.* at 62, the Court recognized that it "would serve no meaningful purpose" to wade into further constitutional challenges "on grounds *such as those asserted* [*t*]*here*," which sought to impose a "failsafe for other, independently adequate measures," unless a prisoner could show a "demonstrated risk of severe pain," *id.* at 61. Without such a concrete "demonstrat[ion]," it is hard to see how a prisoner challenging "a lethal injection protocol *substantially similar* to the protocol . uph[e]ld" in *Baze* could ever show a significant possibility of success on a claim seeking to upset a constitutionally satisfactory protocol. *Id.* The *Baze* plurality's requirement of a "demonstrated risk" would thus appear to be a shorthand way of describing the hurdle that prisoners would need to overcome to show a significant possibility of success on a *Baze*-type claim.

2. Even if *Baze* established a new and uniquely restrictive stay standard, the Court should clarify that this standard applies only to challenges akin to that in *Baze*, and unlike the challenge here. The

Tenth Circuit concluded that *Baze*'s requirement of a "demonstrated risk" applied to "*all* challenges to 'a State's chosen procedure for carrying out a sentence of death.'" J.A. 131 (emphasis added) (quoting *Baze*, 553 U.S. at 48). Whether or not the plurality intended for the "demonstrated risk" language to supplant the classic stay standard, the *Baze* plurality made clear that its reasoning applied only to claims based on "on grounds such as those asserted [t]here," which sought merely a "failsafe for other, independently adequate measures" to a concededly humane drug formula.

Key factors that distinguished the *Baze* challenge are absent here. Oklahoma's new protocol is neither "more humane" than its predecessors, nor supported by a consensus regarding its efficacy or reliability. *Baze*, 553 U.S. at 51; see *id.* at 43 n.1. Oklahoma turned to midazolam as a replacement for pentobarbital without a basis in science. Cf. *id.* at 42; J.A. 327. Instead, the Department of Corrections responded to political pressure to avoid having to delay any executions, J.A. 147, 148, and relied on reports from other States and internet postings from "Wiki leaks or whatever it is," J.A. vol. II 7. Lacking a scientific consensus for Oklahoma's intended purpose, midazolam has been uniformly rejected as a single anesthetic agent for painful procedures *outside* of the capital context, J.A. 206; J.A. 223; J.A. 332-33; Tr. 145, and has only rarely (and not without incident) been used in three-drug lethal-injection protocols.

Most importantly, petitioners claim that Oklahoma's method of execution, even if carried out as written, is unconstitutional. Petitioners contend that midazolam is inherently incapable of reliably creating deep, comalike unconsciousness. That challenge goes to the method of execution and assumes that Oklahoma will carry out its protocol as written. In that

crucial respect, this challenge is fundamentally different than that in *Baze*, where petitioners "simply" were proposing "one more step the State could take as a failsafe for other, independently adequate measures." *Baze*, 553 U.S. at 60-61.

Given these sharp departures from *Baze*, it makes little sense to require petitioners here to show a "demonstrated risk" in the highly restrictive sense that the Tenth Circuit and other courts have interpreted that term, *i.e.*, as requiring proof that the exact same method has produced unconstitutional results in the past. *E.g.*, *Lopez* v. *Brewer*, 680 F.3d 1084, 1090 (9th Cir. 2012) (Berzon, J., concurring in part and dissenting in part from denial of stay of execution) (agreeing that prisoner could not "demonstrate" enough to meet "the high standard" set by *Baze*, and noting that, while prisoners could meet this burden by "demonstrat[ing] that past executions carried out in accord with similar procedures have resulted in executions that violated the Eighth Amendment," such a showing is made "impossible" by repeated changes to a state's protocol).

Clarification as to the stay standard is especially important to ensure that a prisoner has an opportunity to obtain review of a novel execution method, rather than (as in *Baze*) a method that long experience has shown *not* to create an objectively intolerable risk of pain. Were a state to attempt to use some other mild sedative in place of an anesthetic, for example, it should not be able to defeat a prisoner's request to stay his execution simply by saying that because it is the first State to try this particular combination, no objectively intolerable risk can possibly be "demonstrated." A series of exceptionally painful executions is surely one way to demonstrate an intolerable risk, but it cannot be the only way. A stay should

be available if and when a prisoner can show a substantial likelihood of success in proving an Eighth Amendment violation, including by showing that the drugs a state plans to use present a substantial or objectively intolerable risk of imposing severe pain.

III. CONDEMNED PRISONERS NEED NOT PLEAD ALTERNATIVES TO AVOID AN UNCONSTITUTIONALLY CRUEL EXECUTION.

There has long been agreement that the Eighth Amendment places certain means of execution beyond the government's power. The government cannot burn a prisoner at the stake, for instance, nor starve him to death, nor kill him through cruel means resembling torture. See *Baze*, 553 U.S. at 98-99 (Thomas, J., concurring in judgment); *Kemmler*, 136 U.S. at 44; *Wilkerson*, 99 U.S. at 136 (1879) ("[I]t is safe to affirm that punishments of torture . . are forbidden . . . ."). *Baze* established that the administration of a paralytic and potassium chloride to a conscious person would amount to just such an objectively intolerable infliction of pain. There is no difference, from a constitutional perspective, between the sensation of burning and torturous suffocation caused by lethal chemicals or a pyre. In either instance, the Constitution forbids the State from carrying out such an execution, without exception.

The courts below, however, misread *Baze* to hold that an otherwise unconstitutional execution nonetheless may go forward if the condemned prisoner is unable or unwilling to propose a readily available, constitutionally viable means of executing himself. For a petitioner to meet this unprecedented burden, the courts below required that any proposed alternative drug be commercially purchasable by states on the open market. See J.A. 127, 130; J.A. 99 ("[A]n al-

ternative drug that its manufacturer or its distributor or the FDA will not allow to be used for lethal injection purposes is no drug at all for *Baze* purposes." (quoting *Chavez* v. *Florida SP Warden*, 742 F.3d 1267, 1275 (11th Cir.), *cert. denied sub nom. Chavez* v. *Palmer*, 134 S. Ct. 1156 (2014))). On that basis, sodium thiopental and pentobarbital were found to be "not available to the DOC." J.A. 127 ("[S]odium thiopental is now effectively unobtainable anywhere in the United States."); Tr. 296 ("[T]he [State's] vendor . . . didn't want to sell [Oklahoma] pentobarbital any longer."). Affirming that sodium thiopental and pentobarbital drugs are "unavailable" (an assertion undermined by subsequent executions using pentobarbital),[29] the Tenth Circuit held that petitioners' otherwise objectively intolerable executions could proceed. J.A. 127, 130.

That cannot be—and is not—the law. A rule that permits a cruel execution to go forward for immediate lack of a humane alternative runs contrary to controlling precedent, misapplies *Baze*, and cannot be

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[29] Texas, Georgia, and Missouri collectively have carried out six executions using pentobarbital since the petition for certiorari was filed in this case, *see Execution List 2015*, Death Penalty Information Center, http://www.deathpenaltyinfo.org/execution-list-2015 (last visited Mar. 5, 2015), and at least four states—Georgia, Mississippi, Missouri, and Texas—have used or plan to use pentobarbital from compounding pharmacies, *see* Wendy N. Davis, *Compound Sentence: States Keep Mum On Where Lethal Injection Drugs Are Made*, 100-MAR A.B.A. J. 15 (2014); Denise Grady, *Three-Drug Protocol Persists for Lethal Injections, Despite Ease of Using One*, N.Y. Times, May 2, 2014, at A16; *Texas: State Bought Execution Drugs From a Compounding Pharmacy*, N.Y. Times, Oct. 3, 2013, at A21. Oklahoma has not explained why pentobarbital is available to other states but not to Oklahoma.

squared with this Court's constitutional jurisprudence.

1. The Tenth Circuit faulted petitioners for challenging the constitutionality of midazolam without offering a "known and available alternative" to use in its place. J.A. 130. Petitioners clearly pleaded that they are not challenging the constitutionality of lethal injection per se, but seek only to prevent Oklahoma from using this specific combination of drugs. Amended Complaint at ¶ 24, *Warner*, No. 5:14-cv-665 (Oct. 31, 2014). Nevertheless, the Tenth Circuit held that petitioners' failure to plead a readily and commercially available alternative to midazolam independently defeated petitioners' Eighth Amendment claim. See J.A. 130 (citing *In re Lombardi*, 741 F.3d at 895-96 ("Without a plausible allegation of a feasible and more humane alternative method of execution, . . . plaintiffs have not stated an Eighth Amendment claim . . "), *cert. denied sub nom. Zink* v. *Lombardi*, 134 S. Ct. 1790 (2014))).

That holding contravenes *Hill* v. *McDonough*, 547 U.S. 573 (2006), which "unanimously rejected a proposal that . . . suits challenging a method of execution must identify an acceptable alternative." *Jones*, 549 U.S. at 213 (construing *Hill*, 547 U.S. at 581-82). In *Hill*, a prisoner claimed that a state's protocol for administering the first drug in its three-drug protocol risked failing "to render painless the administration of the second and third drugs." 547 U.S. at 578. Hill did not propose an alternative method to use for his execution, though he did concede that, in the abstract, "other methods of lethal injection the Department could choose to use would be constitutional." *Id.* at 580. Reasoning that Hill's claim would, if successful, temporarily prevent the State from executing him, the district court concluded that Hill's suit

amounted to a successive (and impermissible) petition for a writ of habeas corpus attacking his death sentence. *Id.* The U.S. Court of Appeals for the Eleventh Circuit affirmed.

Before this Court, the United States as *amicus curiae* urged that method-of-execution claims should proceed only if "the prisoner identifies an alternative, authorized method of execution." *Id.* at 582. "A suit like Hill's that fails to do so, the United States maintain[ed], is more like a claim challenging the imposition of any method of execution—which is to say, the execution itself—because it shows the complainant is unable or unwilling to concede acceptable alternatives [e]xcept in the abstract." *Id.* (quotations omitted).

The Court unanimously rejected the United States' proposal as imposing "heightened pleading requirements" inconsistent with the Federal Rules of Civil Procedure and the Constitution. *Id.* Instead, the Court concluded that "the traditional pleading requirements" for 42 U.S.C. § 1983 actions raising an Eighth Amendment claim do not include a requirement that a capital litigant propose an alternative method of execution. *Id.* Thus, Hill's underlying contentions about the risks of pain posed by Florida's lethal-injection protocol, without more, stated a claim for relief. *Id.* Petitioners' contentions about the objectively intolerable risks that Oklahoma's method of execution presents are equally sufficient to state a claim for relief, without the necessity of proposing an alternative method. This Court should reaffirm *Hill* and reject the Tenth Circuit's requirement on that ground alone.

2. The Tenth Circuit's "alternative method" requirement also finds little support in *Baze* or this Court's other decisions.

a. *Baze*'s plurality opinion states that a petitioner "must show that the risk [complained of] is substantial *when compared to the known and available alternatives.*" *Baze*, 553 U.S. at 61 (emphasis added). But that statement does not purport to add a new element to Eighth Amendment claims, and had nothing to do with commercial availability. Instead, as discussed above, *Baze* addressed an attempt to compel States to improve upon a settled, concededly humane method of execution. 553 U.S. at 61 (pronouncing stay standard for "grounds such as those asserted [t]here"). The evaluation of alternatives in *Baze* was inescapable, as the point of the challenge was to impose a particular alternative method on the State. The Court concluded that any such alternative, to be constitutionally mandated, would have to be "significantly" more humane than the existing protocol, "feasible"—*i.e.*, more science than fiction—and "readily implemented"—*i.e.*, not prohibitively difficult. *Baze*, 553 U.S. at 52; see *id.* at 62 ("[T]he alternative that petitioners belatedly propose has problems of its own, and has never been tried by a single State."). In short, *Baze* presupposes that the condemned prisoner seeks to force the State to adopt a substantially improved method in lieu of its concededly constitutional method. Given this premise of *Baze*, it is essential that the prisoner's alternative be known and available. If not, a court's imposition of an unavailable alternative would result, de facto, in the State's inability to carry out the capital sentence using its available and constitutional method of execution.

The premise of this challenge is different. Here, the State's proposed method of execution is inherently and unconstitutionally cruel. In that circumstance, a petitioner need not provide the State with a constitutional alternative. See *Baze*, 553 U.S. at 101-02

(Thomas, J., concurring in the judgment) ("It strains credulity to suggest that the defining characteristic of burning at the stake, disemboweling, drawing and quartering, beheading, and the like was that they involved risks of pain that could be eliminated by using alternative methods."); *Warner*, 135 S. Ct. at 826 (Sotomayor, J., dissenting) ("[I]t would be odd if the constitutionality of being burned alive, for example, turned on a challenger's ability to point to an available guillotine."). The cruelty of a punishment is all that petitioners need to establish to prevail.

b. Petitioners' view of *Baze* is supported by the absence of any reference in *Baze* to *Hill* or to a subsequent case rearticulating *Hill*'s holding. See *Jones*, 549 U.S. at 213 ("[*Hill*] unanimously rejected a proposal that . . . suits challenging a method of execution must identify an acceptable alternative.") Had the Court intended to "dramatically limit [*Hill*'s] authority," it would not have done so "*sub silentio*." *Shalala*, 529 U.S. at 18.

c. The Tenth Circuit's requirement also finds no support in other Eighth Amendment decisions. In *Miller* v. *Alabama*, 132 S. Ct. 2455, 2475 (2012), the Court held unconstitutional a juvenile's life-without-parole sentence, but did not require the petitioner to establish (nor did the Court dictate) an alternative prison term. See *Graham* v. *Florida*, 560 U.S. 48, 82 (2010) (same); *Solem* v. *Helm*, 463 U.S. 277, 303 (1983) (same, for non-violent felony). Likewise, in holding that "the Eighth Amendment forbids Congress to punish [wartime desertion] by taking away citizenship," the Court neither discussed nor required the petitioner to propose the contours of what would constitute an appropriate alternative punishment. *Trop* v. *Dulles*, 356 U.S. 86, 103 (1958) (plurality opinion). And in *Weems* v. *United States*, 217 U.S.

349, 382 (1910), the Court held unconstitutional a sentence of 12 years at hard labor in irons for falsifying public records, and vacated the sentence rather than requiring petitioner to propose a less-cruel alternative punishment.

3. It also would be unprecedented to allow the protection of a core constitutional guarantee to turn on the decisions of private corporations who may, or may not, choose or be able to supply products to U.S. prisons. If that were the rule, then purely by dint of economic, regulatory, or marketing conditions, the risks posed by midazolam could be constitutionally intolerable one week and perfectly acceptable the next. The Eighth Amendment's protection against cruelty cannot fluctuate depending on market forces or supply-line interruptions. See *Home Bldg. & Loan Ass'n* v. *Blaisdell*, 290 U.S. 398, 425 (1934) ("Emergency does not increase granted power or remove or diminish the restrictions imposed upon power granted or reserved."); *Ex parte Milligan*, 71 U.S. 2, 120 (1866) (rejecting argument that "necessity" permitted abrogation of the right to trial by jury, and reasoning that "[n]o doctrine, involving more pernicious consequences, was ever invented by the wit of man than that any of [the Constitution's] provisions can be suspended during any of the great exigencies of government"). Such a mutable standard is incompatible with the Constitution's fundamental guarantees of liberty, including freedom from cruel and unusual punishment.

CONCLUSION

For the foregoing reasons, the decision of the court of appeals should be reversed.

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In The Supreme Court of the United States

RICHARD E. GLOSSIP et al.,

Petitioners,

v.

KEVIN J. GROSS et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

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QUESTIONS PRESENTED

1. Does a three-drug lethal injection protocol create a substantial risk of severe pain in violation of the Eighth Amendment when the first drug is highly likely to render the offender unconscious and insensate during the remainder of the execution procedure?

2. Does the *Baze*-plurality stay standard apply when states are not using a protocol substantially similar to the one that this Court considered in *Baze*?

3. When bringing an Eighth Amendment challenge to method of execution under 42 U.S.C. § 1983 must a claimant establish the availability of an alternative method of execution?

TABLE OF CONTENTS

	Page
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED	1
INTRODUCTION	1
STATEMENT OF THE CASE	4
I. Factual Background	4
A. Midazolam	4
B. Oklahoma's Lethal Injection Protocols	9
C. The Execution of Clayton Lockett	14
II. Proceedings Below	17
A. Petitioners' Suit	17
B. Petitioners' Expert Witnesses	18
C. Respondents' Expert Witness	26
D. The District Court's Ruling	28
E. Petitioners' Appeals	30
F. The Execution of Charles Warner	32
SUMMARY OF ARGUMENT	33
ARGUMENT	37
I. THE PETITION SHOULD BE DISMISSED AS IMPROVIDENTLY GRANTED	37
II. OKLAHOMA'S USE OF MIDAZOLAM DOES NOT CREATE A "SUBSTANTIAL RISK OF SERIOUS HARM" TO PETITIONERS	40

TABLE OF CONTENTS – Continued

Page

A. Oklahoma's Protocol Is Highly Likely To Render Petitioners Unconscious And Insensate To Severe Pain During Their Execution 42

B. The District Court Did Not Err By Relying On Oklahoma's Concededly-Qualified Expert Instead Of Petitioners' Expert 45

C. Petitioners' Speculative Criticisms Of Midazolam Do Not Establish That Its Use Puts Them At Substantial Risk Of Serious Harm 49

1. Midazolam's analgesia has no relevance to whether it can render an inmate unconscious and unaware of pain 50

2. The risk of paradoxical effects from midazolam does not pose a substantial risk of pain 51

3. Petitioners failed to present any evidence that midazolam has a ceiling effect that would prevent a 500mg dose from rendering them unconscious and insensate to pain 52

4. Oklahoma's robust procedural safeguards obviate the risk of insufficient anesthesia 55

TABLE OF CONTENTS – Continued

Page

III. PETITIONERS FAILED TO SATISFY EVEN THE MOST RELAXED OF PRELIMINARY INJUNCTION STANDARDS 57

IV. PETITIONERS FAILED TO SHOW THAT ANY RISK WOULD BE SUBSTANTIAL AS COMPARED TO AVAILABLE ALTERNATIVES..... 60

CONCLUSION 67

APPENDIX 1a

TABLE OF AUTHORITIES

Page

CASES

Anderson v. *Bessemer City*, 470 U.S. 564 (1985)..... 48

Arthur v. *Thomas*, 674 F.3d 1257 (11th Cir. 2012)..... 20, 23

Baze v. *Rees*, 553 U.S. 35 (2008)..... *passim*

Belcher v. *Stengel*, 429 U.S. 118 (1976)..... 39, 40

Bond v. *United States*, 131 S. Ct. 2355 (2011)..... 66

Brown v. *Crawford*, 408 F.3d 1027 (8th Cir. 2005)..... 49

Chavez v. *Florida*, 742 F.3d 1267 (11th Cir. 2014), cert. denied, 134 S. Ct. 1156 (2014)..... 26, 38, 49, 61

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Graver Tank & Mfg. Co. v. *Linde Air Products Co.*, 336 U.S. 271 (1949)..... 38

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TABLE OF AUTHORITIES – Continued

Page

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Pavatt v. *Jones*, 627 F.3d 1336 (10th Cir. 2010) ... 10, 61

Raby v. *Livingston*, 600 F.3d 552 (5th Cir. 2010) 31

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TABLE OF AUTHORITIES – Continued

Page

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CONSTITUTIONAL PROVISIONS

U.S. Const. amend. VIII ... *passim*

STATUTES, RULES AND REGULATIONS

Prisoner Litigation Reform Act ... 65

S. Ct. R. 10 ... 38, 39

42 U.S.C. § 1983 ... 18, 64, 65, 66

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Page

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Page

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CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Relevant constitutional and statutory provisions are reprinted at App. 1a, *infra*.

INTRODUCTION

In the dosage called for by Oklahoma's execution protocol, midazolam "is highly likely to render [Petitioners] unconscious and insensate" during their executions. So found the district court, in thorough factual determinations that were affirmed by the court of appeals on clear error review.

Petitioners' allegation-laden opening brief asks the Court to assume the role of a court of error and to substitute Petitioners' proffered facts for the district court's factual findings. But the facts determined by both courts below are well-supported by the record and medical literature, and they make plain that Oklahoma's lethal injection protocol is not cruel and unusual, but rather the most humane form of execution available to the State.

Fact-bound calls to "intrude on the role of [States] in implementing their execution procedures," *Baze* v. *Rees*, 553 U.S. 35, 51 (2008), properly give this Court pause. As a sovereign State vested with the extraordinary responsibility of carrying out the sentences of death meted out by its citizens as punishment for the most heinous crimes, Oklahoma attempts to execute those sentences as humanely, painlessly, and in as

dignified a manner as possible within the means available to it. And "by all accounts," Oklahoma has "fulfilled [its role] with an earnest desire to provide for a progressively more humane manner of death." *Ibid.*

It was Oklahoma that in 1977 tasked its medical experts with developing a more humane alternative to electrocution. The resulting three-drug lethal injection protocol was adopted by every jurisdiction in the United States. When death penalty opponents' attacks on the effectiveness of the first drug, sodium thiopental, proved unsuccessful, they turned to cutting off supplies to the States. Oklahoma led the switch to pentobarbital, which too was adopted by virtually every jurisdiction. Pentobarbital acquired a well-established record of reliability and effectiveness, despite the same accusations that it could not reliably lead to painless executions.

And now, after death penalty opponents have pressured manufacturers of pentobarbital to cut off supplies to the States, Oklahoma again has found itself thrust to the forefront of the search for an acceptable – and available – alternative that will allow it to carry out the sovereign duty assigned to it by the people of Oklahoma. As the district court found, Oklahoma has reasonably determined that alternative to be a drug called midazolam.

As those before them did with sodium thiopental and pentobarbital, Petitioners argue that it is unconstitutionally cruel and unusual for Oklahoma to use a massive dose of midazolam in order to render them

unconscious prior to administration of the drugs that will cause their deaths. Specifically, they argue that the risk that they might be able to perceive pain despite the midazolam – a risk patients and doctors accept every day in undertaking otherwise-painful procedures after administration of a much smaller dose of midazolam – is so substantial as to render the use of midazolam the constitutional equivalent of drawing, disemboweling, and quartering. This cannot be so.

Worse still, feigning ignorance of the very drug shortage that their supporters helped create, Petitioners allege that Oklahoma turned to midazolam not in a good faith effort to find the best available alternative drug but out of callous "expediency." All the while, Petitioners steadfastly refuse to identify a single better option available to Oklahoma. This fact alone demonstrates that this case, under the guise of a narrow attack on a single method of execution out of many, is a full-throated attack on the ability of the sovereign States to carry out the death sentences issued by their citizens.

For these and other reasons, the case should be resolved by either (1) dismissal of the petition for certiorari due to its fact-bound nature and failure to present any question of law upon which there is a lack of uniformity in the lower courts, or (2) affirmance of the Tenth Circuit's judgment.

STATEMENT OF THE CASE

I. Factual Background

A. Midazolam

Midazolam was "developed as a water-soluble benzodiazepine anesthetic agent." Sze-Chuh Cheng & Edward Brunner, *Inhibition of GABA Metabolism in Rat Brain Synaptosomes by Midazolam*, 55 Anesthesiology 41, 41 (1981). It is a "potent sedative agent" with a long record of effective use as a sedative, induction agent, and anesthetic for painful procedures such as intubation, gastroscopy, and cardiac catheterization. FDA-Approved Label for Midazolam, Expert Report of Larry Sasich, Ex. 2, 1.usa.gov/1GLozGY ("Midazolam's FDA Label"); Tr. of Prelim. Inj. Hr'g 368, 599 (Doc. 178) ("Tr."); J.A.76; J.A. vol. II 53 ("J.A.II"). Although most benzodiazepines cannot produce "surgical anesthesia * * * in the absence of other drugs" that depress the central nervous system ("CNS"), "an important exception is midazolam." Dennis S. Charney et al., *The Pharmacological Basis of Therapeutics* 401 (11th ed. 2006); George Brenner & Craig Stevens, *Pharmacology* 192 (4th ed. 2013) ("higher doses [of benzodiazepines] produce * * * anesthesia," even though other "*orally administered* benzodiazepines do not produce significant respiratory depression, coma, or death") (emphasis added).

According to Midazolam's FDA Label, the drug's "efficacy and safety * * * are functions of the dose administered, the clinical status of the individual patient, and the use of concomitant medications capable

of depressing the CNS," and "[a]nticipated effects range from mild sedation to deep levels of sedation virtually equivalent to a state of general anesthesia where the patient may require external support of vital functions." See *supra*. The FDA warns that when a higher-than-therapeutic dose is given, "coma" can result, and that other "serious cardiorespiratory adverse events have occurred * * * [including] respiratory arrest and/or cardiac arrest, sometimes resulting in death." *Ibid.*; J.A.250.

Midazolam's effectiveness as an induction agent has been well-known since at least 1985, when what Petitioners' expert anesthesiologist described as the "landmark" study on midazolam, J.A.230, concluded that "midazolam may be used intravenously for the induction of anesthesia" at doses from 0.1 to 0.4mg/kg. J. G. Reves et al., *Midazolam: Pharmacology and Uses*, 62 Anesthesiology 310, 317-18 (1985). The study describes midazolam as an alternative to sodium thiopental for induction of anesthesia and other purposes. *Id.* at 312, 317, 324. Indeed, "double-blind studies comparing midazolam and thiopental induction and maintenance [of anesthesia]" found that midazolam "proved superior to thiopental because there were fewer adjuvant anesthetics required to maintain an adequate depth of anesthesia" and because it "confers more amnesia." *Id.* at 318.[1]

---

[1] Another study Petitioners' expert anesthesiologist relied on, J.A.233-34, concluded that, in dogs, an infusion rate of 450

(Continued on following page)

Today, thousands of surgeries are performed daily on patients who have been administered a small, 2 to 5mg therapeutic dose of midazolam. This dosage serves two primary purposes. First, it relieves the patient's anxiety and serves as a powerful sedative. Second, the drug has a strong effect on the patient's ability to register and remember pain. See Petra Bischoff & Ingrid Rundshagen, *Awareness Under General Anesthesia*, 108 Deutches Ärzteblatt Int'l 1 (2011), 1.usa.gov/1LSpQjX. Midazolam is also sometimes administered at a higher dose in order to effect not just sedation, but also unconsciousness during intubation and other painful procedures that must be done in preparation for surgery. Once unconscious and intubated, inhaled anesthetics are typically administered to maintain general anesthesia for the remainder of the surgery.

Small doses of midazolam are also routinely used as the sole anesthetic for painful, invasive procedures

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μg/kg/min (31.5mg/min for a 70kg person) of midazolam could be utilized as a sole-anesthetic. Richard I. Hall et al., *The Anesthetic Efficacy of Midazolam in the Enflurane Anesthetized Dog*, 68 Anesthesiology 862, 865 (1988). Notably, 2.5 times more midazolam is required to create the same anesthetic effects in dogs as is required for humans. Yoshimi Inagaki et al., *Anesthetic Interaction Between Midazolam and Halothane in Humans*, 76 Anesthesia & Analgesia 613, 615 (1993). Studies on humans have found that the anesthetic effects of midazolam increased linearly with dosage and estimate that 2mg/kg (140mg in a 70kg person) is enough for full surgical anesthesia. Michael Melvin et al., *Induction of Anesthesia with Midazolam Decreases Halothane MAC in Humans*, 57 Anesthesiology 238 (1982).

like endotracheal intubation, colonoscopies, and gastroscopies.[2] For example, midazolam is used as the sole anesthetic for "rapid sequence intubation," which involves "the administration * * * of a potent induction agent followed immediately by a rapidly acting neuromuscular blocking agent," such as rocuronium bromide, "to induce unconsciousness and paralysis for tracheal intubation."[3] The use of a small 0.1-0.2mg/kg dose to render the patient unconscious and unaware of pain is important in rapid sequence intubation because "[w]hen a paralytic agent is used for intubation without sedation, the patient may be fully aware of his or her environment, including pain, but unable to respond." Caro, n.3, *supra*.

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[2] One study found that many patients who had undergone intubation without anesthesia rated the procedure as a "10 out of 10" on the pain scale. Armando J. Rotondi, *Patients' recollections of stressful experiences while receiving prolonged mechanical ventilation in an intensive care unit*, 30 Critical Care Med. 746, 748 (2002); see also *Howell* v. *State*, No. SC14-167, IX Supp.R. 253-54 (Fla. Feb. 13, 2014) (Dr. Mark Dershwitz testifying that midazolam is able to maintain unconsciousness during intubation, "which all anesthesiologists consider to be an extraordinarily noxious degree of stimulation").

[3] Ron Walls & Michael Murphy, Manual of Emergency Airway Management 221-24 (2012); see also Tr.591; J.A.II.53; David Caro, *Sedation or induction agents for rapid sequence intubation in adults*, UpToDate (Feb. 24, 2015), bit.ly/1BIFX9G; T. Nishiyama et al., *Midazolam for rapid sequence induction*, 39 Japanese J. of Anesthesiology 230 (1990).

Midazolam is also used as the sole anesthetic for dental extractions, J.A.307, and correction of arrhythmias using painful electrical shocks, A.R.J. Mitchell et al., *Diazepam or midazolam for external DC cardioversion*, 5 Eurospace 391 (2003); A. Gupta et al., *Anaesthesia for cardioversion*, 45 Anaesthesia 872 (1990). "[I]n very high doses" midazolam "will completely ablate" or "completely destroy" consciousness. *Muhammad* v. *Sec. Fla. Dept. of Corrections*, No. 3:13-cv-1857, Doc. 1-3, 20 (M.D. Fla. Dec. 23, 2013) (testimony of Plaintiff's expert anesthesiologist Dr. Heath). Thus, although it is not "common to use midazolam for general anesthesia" because other drugs are better suited for "the usual goal [of having] the patient wake up rapidly at the end of the operation," during drug shortages midazolam has been used "as the first and primary drug to induce general anesthesia for surgeries," including brain surgery, in a 50mg dose with no other anesthetic or analgesic. *Howell*, *supra* n.2, IX Supp.R. at 217-19, 233-34; Tr.621-23. Finally, during end-of-life palliative care, where medication is used "to relieve intolerable suffering * * * by a reduction in patient consciousness" and awareness, sometimes to "continuous and deep" levels, midazolam is recommended as the "first-line choice." Alexander de Graeff & Mervyn Dean, *Palliative Sedation Therapy in the Last Weeks of Life*, 10 J. Palliative Medicine 67 (2007).

B. Oklahoma's Lethal Injection Protocols

Oklahoma developed lethal injection as a method of execution in 1977, after the Oklahoma Legislature directed the state medical examiner to find a more effective and humane alternative to electrocution. That protocol included (1) sodium thiopental, a fast-acting barbiturate that caused unconsciousness, (2) vecuronium bromide, a neuromuscular blocking agent that inhibited all muscular-skeletal movements and, by paralyzing the diaphragm, stopped respiration,[4] and finally (3) potassium chloride, which interfered with the electrical signals that stimulate the contractions of the heart, inducing cardiac arrest. *Baze* v. *Rees*, 553 U.S. 35, 44 (2008).

This protocol proved highly effective. By 2008, when this Court decided *Baze*, virtually every jurisdiction with the death penalty had adopted the protocol. *Baze*, 553 U.S. at 42-43.

Once *Baze* effectively foreclosed further challenges to the protocol, anti-death penalty activists began

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[4] Unlike the circumstances in *Baze*, Oklahoma law and current veterinary guidelines for the euthanasia of animals allow the use of neuromuscular blocking agents so long as the animal is "anesthesized or unconscious" prior to administration of the paralytic. American Veterinary Medical Association, Guidelines for the Euthanasia of Animals 34 (2013), bit.ly/RVjJAW.

pressuring manufacturers of sodium thiopental to restrict its sale to States so that the States would be forced to alter the protocol, opening up new opportunities for Eighth Amendment challenges to delay executions. In 2011, "after months of pressure by activists" and under threat of legal liability in Europe, the sole American provider of sodium thiopental was forced to exit the market in the United States.[5] Supplies of sodium thiopental began to dwindle, and the drug became impossible for the States to obtain. *Pavatt* v. *Jones*, 627 F.3d 1336, 1338 n.1 (10th Cir. 2010).

In response, Oklahoma led the switch to pentobarbital, and most other States soon followed suit.[6] Pentobarbital proved highly effective, but its manufacturer began taking steps to prevent States from obtaining the drug for use in executions.[7] Supplies dwindled, and the States were again forced to begin searching for an alternative to ensure the most humane execution.

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[5] Nathan Koppel, *Drug Halt Hinders Executions in the U.S.*, The Wall Street Journal (Jan. 22, 2011), on.wsj.com/1C7ehOd.

[6] *E.g.*, *Pavatt*, 627 F.3d at 1337-38; Jim Salter, *Missouri Prisons Receive New Execution Drug, Pentobarbital*, Huffington Post (Oct. 23, 2013), huff.to/1D2uZ4I.

[7] David Jolly, *Danish Company Blocks Sale of Drug for U.S. Executions*, N.Y. Times (July 1, 2011), nyti.ms/1HOSzj2.

Some States, including Oklahoma, began sourcing pentobarbital from compounding pharmacies. Condemned inmates sued the States claiming that the use of compounded pentobarbital constituted cruel and unusual punishment. Oklahoma's supplier of compounded pentobarbital came under intense pressure from death penalty opponents to cease compounding pentobarbital for use in executions, and subsequently declined to continue supplying the drug to Oklahoma. Ltr. Pharmacy to ODOC (Doc. 64-6). After an exhaustive search for a new supplier proved fruitless, Oklahoma was forced to identify a replacement for pentobarbital. Tr.309-10, 317.[8]

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[8] Petitioners, for the first time in this litigation, suggest that pentobarbital is available to Oklahoma, Pet. Br. 47 n.29, asking Oklahoma to "explain[ ]" the unavailability – which Oklahoma has satisfactorily done to the district court and court of appeals, J.A.67, 115 – ignoring *their* burden to show that the drug *is* available. Regardless, those States that have continued to use pentobarbital rely on dwindling stockpiled supplies. Michael Graczyk, *Texas seeks to replenish low supply of execution drugs amid pending court order to ID supplier*, U.S. News & World Report (Mar. 9, 2015), bit.ly/1Gcuapt (noting supply problems with pentobarbital in Texas, South Carolina, and Georgia); Emma Lacey-Bordeaux, *Texas nearly out of execution drug*, CNN (Mar. 10, 2015), cnn.it/1N4flqL. Oklahoma has never stopped pursuing new supplies of sodium thiopental and pentobarbital, but those efforts have proven unsuccessful.

After exploring a variety of options, several States concluded that midazolam would make an effective alternative to pentobarbital.[9]

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[9] Ohio and Arizona began using midazolam as part of a conceptually different two-drug protocol, using hydromorphone (an opiate) in conjunction with midazolam to depress the inmate's respiratory drive and cause death. The protocol has been ineffective at causing a swift death, resulting in several executions taking longer than expected. Both Ohio and Arizona have announced that they will discontinue use of that two-drug protocol. Michael Kiefer, *Arizona to Change Drugs Used for Executions*, USA Today (Dec. 23, 2014), usat.ly/1yqrFJw; Matt Pearce, *Ohio Won't Use Controversial Drug Combo for Executions Anymore*, L.A. Times (Jan. 8, 2015), lat.ms/1bHp2xX. Oklahoma likewise will not use that two-drug combination. J.A.118 & n.3.

Those executions are not probative of whether the entirely different drug protocol at issue here is effective because they administered midazolam in a different dose and method than in Oklahoma and Florida's protocol. In Ohio, only 10mg of midazolam is used, which is at the bottom end of the therapeutic range used for induction. J.A.217. In the Joseph Wood execution, Arizona used fifteen 50mg doses of midazolam spread out over a nearly two hour period. M. Alex Johnson, *Arizona Needed 15 Drug Doses To Execute Joseph Wood*, NBC News (Aug. 1, 2014), nbcnews.to/1rXAQ4M. Petitioners' expert testified here that intravenous midazolam has a peak effect 2-3 minutes after injection, Tr.116, and the drug has a "brief half-life," Reves, p.5, *supra*, at 318-19. There is a significant pharmacological difference between a single, rapidly introduced 500mg dose and 50mg doses spaced out over two hours. Tr.667. Moreover, thorough reviews of those executions concluded that the inmates were "fully sedated, w[ere] totally unresponsive to stimuli, and as a result did not suffer." Mayra Cuevas, *Two-Hour Execution Followed Correct Protocol, Says Independent Report*, CNN (Dec. 22, 2014), cnn.it/1EE9LFb; see also Eyder Peralta, *Ohio Will*

(Continued on following page)

In October 2013, Florida began using midazolam as the first drug in a three-drug protocol after extensive litigation unsuccessfully challenging the constitutionality of that protocol. J.A.101-02. Florida has since conducted eleven executions using that protocol without incident.

As the Oklahoma Department of Corrections ("ODOC") began its search for a new drug, it consulted with its counterparts in other states, including Texas, Illinois, and Arizona. J.A.II.1-2, 8. Based on these consultations, ODOC's general counsel began researching midazolam by reviewing the expert testimony that was provided in federal court litigation in Florida, where Florida's use of midazolam had been unsuccessfully challenged. J.A.II.2, 4. The general counsel also consulted with ODOC's medical director, conducted research of his own,[10] and consulted with the Oklahoma Office of the Attorney General, which advised ODOC that in light of the evidence and Florida's record of successful use of midazolam, its use comports with the Eighth Amendment. J.A.II.3, 5-8; J.A.145-47. ODOC determined that, unlike the alternatives, midazolam was readily obtainable.

Increase Dosage of Drugs in Lethal Injection, NPR (Apr. 28, 2014), n.pr/1CnbXm4.

[10] Petitioners have persisted in their misleading assertion that ODOC's general counsel's research was limited to "wikileaks [sic]" when in fact the general counsel's testimony was that he "went past" such sources to perform more in-depth research into the drug. J.A.II.7.

Based on this vetting, ODOC elected to revise its protocol to include the three-drug protocol at issue here: midazolam, followed by vecuronium or recuronium bromide, then potassium chloride. J.A.145-50; Tr.297.

C. The Execution of Clayton Lockett

Oklahoma began use of the midazolam-based three-drug protocol in 2014 with the execution of Clayton Lockett. Problems with the execution began even before it started. While in his cell, Lockett cut himself in the crook of his arms in an apparent attempt to impede IV access. J.A.50. Once Lockett was transferred to the execution chamber, Oklahoma's personnel had unprecedented difficulty setting an IV. J.A.51-53. The attending physician eventually was able to set a functioning IV in Lockett's femoral artery near the groin. J.A.52. Due to the sensitive location of the IV insertion point, the ill-fated decision was made to cover it with a sheet so as to preserve Lockett's dignity. J.A.52.

Shortly after administration of the midazolam began, the IV failed; because the IV insertion point was covered, this failure was not immediately detected. J.A.53-56. Enough midazolam made it into Lockett's bloodstream to cause temporary induction of unconsciousness, but not enough to maintain an adequate level of unconsciousness. J.A.53-57. Because the IV failed, the remaining midazolam, vecuronium bromide, and potassium chloride were injected into Lockett's muscle tissue, where they were partially

and slowly absorbed, eventually causing his death. J.A.54-56.[11] It is not clear whether Lockett suffered severe pain before his death. J.A.55, 70; J.A.II.50; Tr.617.

Oklahoma immediately launched a thorough investigation to determine the mistakes made and how to prevent them. J.A.379. After a five month investigation, Oklahoma Department of Public Safety investigators concluded that Lockett's prolonged execution was caused by (1) the use of a short needle in setting a femoral IV, which rendered the IV prone to failure, and (2) the decision to cover the IV insertion point with a sheet, resulting in failure to discover the IV problems. J.A.376-419.

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[11] The concentration of midazolam found in Lockett's bloodstream was slightly higher than would be expected had Lockett received a therapeutic dose of midazolam and approximately *half* the amount than what is given to patients as anesthesia for surgery. J.A.374-75. Contrary to Petitioners' claim, Pet. Br. 20, much less than the intended 100mg dose of midazolam actually made it into Lockett's system because the IV failed *during* administration of midazolam, not after. J.A.56. Also inaccurate is Petitioners' related claim that the IV failure was irrelevant because midazolam "has a rapid absorption rate, even if not administered intravenously." Pet. Br. 20 n.22. Petitioners' own expert testified that when injected intravenously, midazolam has a peak effect at 2-3 minutes, whereas with intramuscular injection, initial effects are not seen until 10-15 minutes after injection, with peak effect occurring at approximately 60 minutes. Tr.116-17; J.A.328. Lockett began to move 10 minutes after the midazolam injection, and died 33 minutes later. J.A.392-95. Lockett's execution provides no probative evidence as to the efficacy of a correctly-administered 500mg (or 100mg) intravenous dose of midazolam.

In response, the ODOC extensively revamped its execution protocol, which included rigorous new training requirements, a complete remodel of the execution chamber and its equipment, and new monitoring requirements. J.A.57-66, 361-69.

Oklahoma's revamped execution protocol requires the presence of two medical professionals to establish and monitor IVs, determine and monitor consciousness, and pronounce death, as part of the "IV Team." J.A.58. For Petitioners' executions, the IV Team will include a physician and paramedic. J.A.63-64.

The execution room is now equipped with an ultrasound machine to locate veins when setting IVs and with all equipment medically necessary to gain IV access. J.A.66. To aid in monitoring the IVs after they are established, the execution chamber is equipped with three high-definition video cameras, one fixed over the top of the inmate and two that are capable of tilting, panning, and zooming. J.A.64. The feeds from these cameras are viewed by the IV Team on high-definition monitors in the execution room, where they can also see directly into the execution chamber through one-way glass. J.A.64. The execution room is equipped with primary and backup electrocardiograph machines to monitor the inmate's pulse, blood pressure, and respiration from the beginning of administration of the drugs until death is pronounced. J.A.66.

Once the IV Team has confirmed that the IVs are functioning, the midazolam is administered and the physician "physically confirm[s] the offender is unconscious by using all necessary and medically appropriate methods." J.A.65. Only after the physician is satisfied that the inmate is unconscious and insensate are the second and third drugs administered. During administration of those drugs, the IV Team continuously monitors the inmate, including the use of the EKG, for any indications of consciousness, and continues to do so until death is pronounced. J.A.63-65.

II. Proceedings Below

This appeal arises out of a motion for preliminary injunctions filed by four inmates on Oklahoma's death row, each scheduled to die in 2015. Charles Warner anally raped and murdered an eleven-month old girl; Richard Glossip hired his coworker to kill their employer by beating him to death with a baseball bat; John Grant murdered a food service supervisor in the correctional facility in which he was a prisoner by repeatedly stabbing her to death with a shank; and Benjamin Cole murdered his nine-month-old daughter by snapping her spine in half. J.A.49-50, 113-14.

A. Petitioners' Suit

Petitioners, along with eighteen other Oklahoma inmates sentenced to death, alleged eight counts in

their Section 1983 suit against various ODOC officials. Only Count 2 remains at issue.

Count 2 alleges that Oklahoma's use of midazolam as the first drug in the three-drug protocol creates a substantial risk that an inmate would experience "severe pain, needless suffering, and a lingering death," and thus violates the Eighth Amendment. J.A.119.

On November 10, 2014, Petitioners filed a motion for preliminary injunction asking the district court to bar Oklahoma from implementing the midazolam-based protocol and executing the Petitioners until a ruling on the merits. J.A.120. In December 2014, the district court held a three-day evidentiary hearing on the motion for preliminary injunction. *Ibid.*

B. Petitioners' Expert Witnesses

Petitioners presented two expert witnesses on the subject of midazolam's properties: anesthesiologist David Lubarsky and pharmacist Larry Sasich.

1. Dr. David Lubarsky. Lubarsky is a frequent witness for challengers to the constitutionality of lethal injection and has long been a crusader against the use of sodium thiopental in lethal injections. His "zeal" to end the use of three-drug protocols has prompted criticism by even those who otherwise agree with his opposition to lethal injection. See, e.g.,

Groner, *Inadequate Anaesthesia in Lethal Injection for Execution*, 366 Lancet 1073, 1073 (2005).[12]

Lubarsky's claims about the inappropriateness of sodium thiopental sparked the litigation that culminated in this Court's decision in *Baze*, 553 U.S. at 67 (Alito, J., concurring), but the Court ultimately was not persuaded by the claims Lubarsky made in his article *Inadequate Anaesthesia in Lethal Injection for Execution*, 365 Lancet 1412 (2005). The *Baze* plurality noted the "controversy surrounding" Lubarsky's scholarship, pointing to the "peer responses by seven medical researchers criticiz[ing] the methodology supporting the [article's] original conclusions," *Baze*, 553 U.S. at 51 n.2. Justice Alito likewise pointed out that Lubarsky's article had been "questioned," *id.* at 67, while Justice Breyer described Lubarsky's scholarship as perhaps "seriously flawed" and incapable of being given "significant weight," *id.* at 109 (citing Groner, *supra*). See also *West* v. *Schofield*, 380 S.W.3d 105, 114-16 (Tenn. 2012) (rejecting Lubarsky's opinions on sodium thiopental).

Once the States began replacing sodium thiopental with pentobarbital, Lubarsky shifted his criticisms to that drug. When called as an expert witness in a

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[12] Lubarsky's criticisms of sodium thiopental were similar to those he now levies at midazolam. For example, he claimed that thiopental was improper because it "is used solely to induce a few moments of anesthesia prior to administering additional agents." David A. Lubarsky et al., *Lethal Injection for Execution: Chemical Asphyxiation?*, 4 PLoS Med. 646, 650 (2007), bit.ly/19MwZ4q.

challenge to Alabama's use of pentobarbital, Lubarsky raised now-familiar attacks, claiming it was "designed to produce sedation, not anesthesia" and that the FDA had not approved it for use as "an anesthesia induction agent." *Arthur* v. *Thomas*, 674 F.3d 1257, 1266 (11th Cir. 2012) (Hull, J., dissenting). Lubarsky argued that "there is no scientific literature establishing the anesthetic dose of pentobarbital" and that the dose of pentobarbital to be given could not reliably "assure that an inmate is unconscious when given pancuronium bromide and potassium chloride." *Ibid.*

As was the case with his opinions regarding sodium thiopental, Lubarsky's opinions regarding pentobarbital never won the day. Both drugs proved effective at rendering inmates unconscious and insensate.

Undeterred, Lubarsky claimed to the district court here that "all" of Oklahoma's drug protocols, including those using sodium thiopental and pentobarbital, were "actually constructed to produce egregious harm and suffering," and that even properly administered, sodium thiopental was "insufficient to render a patient unconscious through the entirety of the execution," J.A.226-27 – a claim even the challengers in *Baze* distanced themselves from.

Lubarsky's campaign has now shifted to midazolam. Lubarsky testified to the district court in this suit that he had overseen the administration of midazolam "a million times," both for sedation and to induce anesthesia. J.A.203-04. In his experience, a 2

to 5mg dose was typical for sedation, while a 30 to 50mg dose was typical for inducing anesthesia. J.A.217. Lubarsky agreed that deaths had occurred from midazolam at doses as small as .04 to .07mg/kg (for a 70kg patient, 2.8 to 4.9mg). J.A.217. He argued, however – without citing any source – that "those type of fatalities occur in 90-year-olds with congestive heart failure who have not had careful titration of the drug," *ibid.*, a claim undermined by Midazolam's FDA Label, which warns of "serious and life-threatening cardiorespiratory adverse events" requiring monitoring "regardless of age or health status."[13]

Lubarsky conceded that if someone were administered a 500mg dose of midazolam intravenously, it would take "[n]o more than a couple of minutes for sure, probably less" for them to be rendered unconscious. Tr.117. Lubarsky likewise did not dispute that such a dose was capable of placing someone in a "surgical plane of anesthesia"; rather, Lubarsky's criticism of midazolam was that, in his estimation, it could not "reliably" place someone in that deep level of unconsciousness. J.A.228. When pressed as to how

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[13] These deaths are well-documented in the literature. See, e.g., Peter L. Bailey et al., *Frequent Hypoxemia and Apnea after Sedation with Midazolam and Fentanyl*, 73 Anesthesiology 826, 826 (1990) (noting "[m]ore than 80 deaths have been associated with the use of midazolam" in "surgical procedures in the United States"); *Reducing Risk of Midazolam Overdose in Adults*, National Patient Safety Organization (Dec. 9, 2008), http://bit.ly/18UybBK (describing deaths of patients after low doses of midazolam); J.A.309.

he reached this conclusion, Lubarsky admitted that he could not opine as to a specific degree of reliability because "no one is ever given doses like this." Tr.145.

Lubarsky speculated that the alleged lack of reliability was due to midazolam's alleged "ceiling effect." J.A.171-72. In support of this claim, Lubarsky's report cited two sources. One concerned the EEG effect of midazolam in rats, Suzanne Hovinga et al., *Pharmacokinetic-EEG effect relationship of midazolam in aging BN/BiRij rats*, 107 Brit. J. Pharmacol. 171 (1992), and the other was a material safety data sheet on midazolam, J.A.179-83. Neither source makes any mention of a "ceiling effect" or the level of consciousness at which that effect would occur.[14] Lubarsky was

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[14] In a declaration submitted on appeal and never presented to the district court, Lubarsky referenced two other sources for his claim that there was a "clearly demonstrated" ceiling effect. J.A.233-34. First, in a study on 15 dogs (only 5 of which were given high doses) seeking to determine if the amount of inhaled anesthetic necessary for surgery could be reduced by combining it with midazolam, the authors theorized that midazolam "may" have a ceiling effect but also noted that the data only showed that the effects from midazolam *slowed* at a certain level, but not ceased. Hall, *supra* n.1.

Lubarsky claims that his second after-the-fact source noted a ceiling effect at approximately 0.3mg/kg. J.A.233 (citing D. J. Greenblatt et al., *Kinetics and EEG effects of midazolam during and after one-minute, one-hour, and three-hour intravenous infusions*, 44 J. Clin. Pharmacol. 605 (2004). The study – which, contrary to Lubarsky's claims, was not aimed at determining any ceiling effect – examined "8 volunteers [who] received midazolam (0.1 mg/kg) by constant-rate intravenous infusion." *Id.* at 605. There is no mention of any 0.3mg/kg dose as claimed by Lubarsky, much less any "ceiling effect." *Id.* at 606.

unable to render an opinion as to the dosage at which this alleged ceiling effect occurred. J.A.225.

Lubarsky also argued that the risk of paradoxical reactions and the lack of analgesic effect rendered midazolam ineffective as an anesthetic. As to the former, Lubarsky claimed that in "1 to 11 percent" of cases, rather than sedating a patient and reducing their anxiety, benzodiazepines have the opposite effect, and cause agitation and an "outward manifestation that looks like anxiety." J.A.210-11. In his expert report, Lubarsky agreed that paradoxical reactions "are not attended by the expected sedative effects," J.A.172-73, but on the stand, Lubarsky for the first time claimed that paradoxical reactions can occur *after* sedation, based on unspecified "case reports." J.A.228.

On analgesia, Lubarsky argued that because midazolam is not an analgesic, it is unsuitable for use as a sole anesthetic. J.A.171. He claimed in this regard that "midazolam differs significantly and materially from barbiturates like pentobarbital, which are approved as sole anesthetics." J.A.172. However, the FDA-approved drug label for pentobarbital does not list induction or maintenance of anesthesia as an approved indication or usage, and states that pentobarbital has "little analgesic action" and "may increase the reaction to painful stimuli." DailyMed, *Label: pentobarbital sodium injection* (May 2012), 1.usa.gov/1COEl25; *Arthur*, 674 F.3d at 1266; J.A.261-62.

Lubarsky also claimed that midazolam was "deemed insufficient for surgical anesthesia in any dose form by the FDA," Tr.145, a claim contradicted by his co-expert, Dr. Larry Sasich, who admitted that it was unknown whether midazolam was even submitted to the FDA for consideration as a surgical anesthetic or whether instead the manufacturer simply "never attempted to market the drug as an anesthetic." J.A.262, 265. Nor did Lubarsky explain the medical relevance of FDA approval, given the rampant off-label use of other drugs for general anesthesia.[18]

Lubarsky acknowledged that midazolam is frequently used "to basically get the patient off to sleep so that you can then * * * do some minor procedures" but claimed that those minor procedures were only "things that don't have a great deal of noxious stimuli, painful stimuli, like colonoscopies." J.A.223. Lubarsky later stated, however, that "midazolam unconsciousness is actually sufficient" to resist the

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[18] For example, virtually every drug used for general anesthesia in pediatric patients has not been approved by the FDA for that purpose, yet that use is widely accepted in the medical community. D. R. Doherty, *Off-label drug use in pediatric anesthesia and intensive care according to official and pediatric reference formularies*, 57 Can. J. Anaesthesiology 1078, 1078-79 (2010); see also James Aisenberg, *Propofol Use Under the Direction of Trained Gastroenterologists: An Analysis of the Medicolegal Implications*, 101 Am. J. Gastroenterology 707 (2007); Nancy Chang et al., *What's in a Label?*, 103 Anesthesiology 179, 181-83 (2005) (describing many off-label uses in anesthesiology).

painful noxious stimuli associated with the setting of a femoral IV, a process that involves "digging dee[p] into the tissue," to access the femoral vein, which "is buried deep, usually a couple of inches below the skin's surface." J.A.229.

2. Dr. Larry Sasich. Sasich was educated as a pharmacist, but describes himself as a "drug information" specialist. J.A.257. Sasich currently operates a company that publishes "Patient Drug News Limited." Like Lubarsky, Sasich opined that midazolam was "inappropriate" as a lethal injection drug for three reasons: (1) lack of analgesia, (2) alleged ceiling effect, and (3) risk of paradoxical effects. J.A.260.

Regarding analgesia, Sasich simply noted that midazolam had not been approved by the FDA for use as an analgesic, without any explanation as to why this was relevant to its effectiveness as an anesthetic. J.A.261.

Regarding ceiling effect, Sasich based his conclusion that midazolam has a ceiling effect primarily on the fact that "*all* drugs essentially have a ceiling effect." Tr.343 (emphasis added). Sasich testified that he "did a [literature] search to try and determine at what dose of midazolam you would get a ceiling effect for unconsciousness and I couldn't – I could not find one." Tr.344; J.A.243-44.

As to paradoxical reactions, Sasich testified that "[t]he precise risk or incident of [paradoxical] reactions cannot be calculated" because "we simply don't have th[e] information" for midazolam. Tr.348;

J.A.244. In his expert report, Sasich's only support was two case reports of paradoxical reactions – both of which stated that at no point did patients feel pain during surgery or examination – out of millions of administrations of midazolam every year, demonstrating the extraordinary rarity of such paradoxical reactions. J.A.245.

C. Respondents' Expert Witness

On the subject of the efficacy of midazolam, Oklahoma called Dr. Lee Evans, a doctor of pharmacy who currently serves as Dean of Auburn University's School of Pharmacy. Dr. Evans' testimony regarding the use of midazolam in identical execution protocols has been relied upon by several courts. See, e.g., *Chavez* v. *Florida*, 742 F.3d 1267, 1270-71 (11th Cir. 2014), cert. denied, 134 S. Ct. 1156 (2014); *Howell* v. *State*, 133 So.3d 511, 519-22 (Fla. 2014), cert. denied, 134 S. Ct. 1376 (2014); *Muhammad* v. *State*, 132 So.3d 176, 188, 193-96 (Fla. 2013), cert. denied, 134 S. Ct. 894 (2014).

Dr. Evans testified that, when used as a pre-anesthetic sedative, the typical therapeutic dose for 70kg adult under the age of 60 would be 1.5 to 3.5mg. J.A.308. Like Dr. Lubarsky, Dr. Evans testified that fatalities have occurred from midazolam in doses as

low as 0.04 to 0.07mg/kg (2.8 to 4.9mg for a 70kg adult). Compare *ibid.* with J.A.217.[16]

Dr. Evans agreed that midazolam "is not an analgesic," but testified that this was irrelevant because a 500mg intravenous dose of midazolam would depress the central nervous system to a point that would "render the person unconscious and 'insensate' during the remainder of the procedure." J.A.309-11. In Dr. Evans' opinion, "the proper administration of 500mg of midazolam * * * make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from application of the 2nd and 3rd drugs." *Ibid.*

Dr. Evans explained that midazolam's anesthetic effect stemmed from its depression of the central

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[16] Petitioners question Dr. Evans on the basis that a material safety data sheet for midazolam described a lowest reported toxic dose as being 71mg/kg, but Dr. Evans in his report described the lowest reported toxic dose as .071mg/kg. This discrepancy was the result of Dr. Evans having inadvertently attached the data sheet for preservative-free midazolam – a data sheet that contains an apparent typographical error. The data sheet from that manufacturer for midazolam containing preservatives – which all parties acknowledge is the midazolam used by Oklahoma, J.A.179, 251 – correctly states that the lowest reported toxic dose is 71 *micro*grams/kg, the equivalent of .071mg/kg, just as Dr. Evans stated. Bedford Laboratories Material Safety Data Sheet for Midazolam, http://www.benvenue.com/content/dam/internet/opu/benvenue/com_EN/documents/products/midazolam/MidazolamInjectionRev32007.pdf. In any event, both Dr. Evans and Dr. Lubarsky agreed that other sources established a history of fatalities at doses ranging from .04 to .07mg/kg. J.A.217, 294.

nervous system function by binding to gamma-aminobutyric acid ("GABA") receptors in the body. J.A.312-13. Dr. Evans testified that there are GABA receptors along the entire length of the central nervous system, not just in the spinal cord, and that midazolam binds to those GABA receptors such that the brain is effectively paralyzed, no longer capable of being aware of pain. J.A.314.

Dr. Evans agreed that paradoxical reactions were possible with midazolam, but testified that their incidence was very low, and occurred at low, therapeutic doses. J.A.315. At a 500mg dose, Dr. Evans testified, a paradoxical reaction was unlikely because the central nervous system would be effectively shut down. *Ibid.*

Regarding the "ceiling effect," Dr. Evans testified that the effect of 500mg of midazolam on GABA receptors in the brain would be such that the recipient would be rendered unconscious and insensate. J.A.312-13.

D. The District Court's Ruling

The district court issued an extensive oral ruling denying Petitioners' motion for preliminary injunction because Petitioners failed to establish a likelihood of success on the merits on any of their five claims. J.A.41. The court also concluded that Petitioners "failed to establish any of the [other] prerequisites to a grant of preliminary injunctive relief." J.A.41-42.

The district court found that "[t]he 500 milligram dosage of midazolam, as called for in * * * the revised protocol, is many times higher than a normal therapeutic dose of midazolam" and "will result in central nervous system depression as well as respiratory arrest and cardiac [ar]rest." J.A.76-77. The court further found that a 500mg dosage of midazolam "is highly likely to render the person unconscious and insensate during the remainder of the procedure" and that, "[c]onsequently, analgesia, from midazolam or otherwise, is not necessary." J.A.77. In sum, the court found that "[t]he proper administration of 500 milligrams of midazolam * * * would make it a virtual certainty that an individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from application of the second and third drugs." *Ibid.*

The district court expressly found "persuasive[ ]" the testimony of Dr. Evans that "whatever the ceiling effect of midazolam may be with respect to anesthesia * * * there is no ceiling effect with respect to the ability of a 500 milligram dose of midazolam to effectively paralyze the brain," J.A.78, "shutting down respiration and eliminating the individual's awareness of pain." *Ibid.* Likewise, the court found that even "with a low therapeutic dose of midazolam there would be less than a 1 percent incidence of a paradoxical reaction," but "[n]o data [was] available to show what * * * the likelihood of a paradoxical reaction would be with a 500 milligram IV dose of midazolam." J.A.78-79. Thus, the court determined that risk "speculative" at best. J.A.78. The court also "place[d]

considerable reliance" on certain "aspects of the [revised] lethal injection protocol" including the requirement that "the offender's level of consciousness must be monitored throughout the procedure." J.A.97.

The district court found Petitioners' allegation that "[i]t would be feasible to use sodium thiopental in a single-drug formulation to" carry out their executions groundless. J.A.124-25. In particular, the court found that "the defendants have affirmatively shown that sodium thiopental and pentobarbital * * * are not available to the DOC." J.A.68.

E. Petitioners' Appeals

A unanimous panel of the court of appeals affirmed the district court's preliminary injunction denial. J.A.113.

In response to Petitioners' claim that the district court abused its discretion by relying on Dr. Evans' testimony, the court of appeals noted that Petitioners did "not argue that the district court failed to make adequate *Daubert* findings regarding Dr. Evan's [sic] testimony." J.A.135. The court of appeals credited the "detail" with which the district court performed its gatekeeper role and concluded that "there is no question that the district court * * * applied the proper standards in doing so." J.A.133. The court of appeals likewise held that the district court "aptly" concluded that Dr. Evans' "extensive" experience and "considerable" qualifications made him well-suited to opine on the issue at hand. J.A.134.

After "carefully examining the record on appeal," the Tenth Circuit concluded that none of the district court's findings were clearly erroneous. J.A.136-37. The court noted Petitioners' criticisms of Dr. Evans' testimony but held that, even if taken as true, those criticisms did not undercut his testimony on the critical question of whether 500mg of midazolam would render Petitioners unconscious and insensate. J.A.137.

In an alternative holding, the court of appeals concluded that the district court had properly construed and applied the test articulated by this Court in *Baze*, which requires in its second prong that an inmate seeking a stay of execution "show that the risk is substantial when compared to the known and available alternatives." J.A.130 (quoting *Baze*, 553 U.S. at 61). Plaintiffs did not identify any available alternative. J.A.130. Nonetheless, this conclusion was unnecessary to the disposition of the case because "the plaintiffs have failed to establish that the use of midazolam in their executions * * * creates a demonstrated risk of severe pain." *Ibid.* (citing *Raby* v. *Livingston*, 600 F.3d 552, 560 (5th Cir. 2010)).

On January 13, 2015, Petitioners petitioned this Court for certiorari and filed an accompanying application for a stay of their executions. Respondents filed oppositions to both the next day. On January 15th, this Court denied the application for stay.

On January 23rd, this Court granted the petition for writ of certiorari. Three days later, Oklahoma filed

an application to stay the executions of the remaining Petitioners, which the Court subsequently granted.

F. The Execution of Charles Warner

After this Court denied his request for a stay, Oklahoma executed Charles Warner, using the three-drug protocol at issue here. The execution was completed without incident. Glenn Puit, *Oklahoma executes Charles Frederick Warner without incident*, EnidNews.com (Jan. 15, 2015), bit.ly/1LQOtgY.[17]

Warner "los[t] consciousness quickly." Erik Eckholm, *Oklahoma Executes First Inmate Since Slipshod Injection in April*, N.Y. Times (Jan. 15, 2015), nyti.ms/1DSMLan. Five minutes after the midazolam was administered, the attending physician checked Warner for consciousness, utilizing a variety of medical techniques. Satisfied that Warner was insensate to these stimuli, the physician informed the execution team that Warner was unconscious, and the second and third drugs were administered. Warner "showed no

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[17] Petitioners falsely imply that there were indications that the midazolam did not work in the Warner execution. Pet. Br. 22. Warner's last words were, "my body is on fire," but it is undisputed that Warner said this immediately after the administration of midazolam began and *before* injection of the second and third drugs. Petitioners' own source states, because "[Warner] began complaining about the effects on his body before the drugs were administered," it raises questions "whether he may have exaggerated his symptoms to help his fellow death row inmates' case." Sean Murphy, *Dying Oklahoma Inmate's Last Words Stir Questions*, N.Y. Times (Jan. 16, 2015), http://nyti.ms/1y0rJ2s.

physical signs of distress," and by all accounts, "it appeared the [midazolam] worked." Puit, p.32, *supra*; see also M. Delatorre, News Channel 4 (Jan. 15, 2015), bit.ly/1xe0eqT; Sean Murphy, *Inmate Shows No Obvious Distress in Oklahoma Execution*, N.Y. Times (Jan. 16, 2015). The physician and paramedic continuously monitored Warner for signs of consciousness, both visually and by monitoring an EKG which displayed Warner's vital signs. Eighteen minutes after the execution began, Warner was pronounced dead. Puit, p.32, *supra*.

SUMMARY OF ARGUMENT

I. Petitioners present no issues appropriate for resolution by this Court and their petition should be dismissed as improvidently granted. This Court is not in the practice of reviewing cases like this where (1) the asserted error consists of erroneous factual findings of two courts below; (2) the purportedly erroneous holding was not necessary to the judgment below; and (3) the courts of appeals that have addressed the issue are in agreement. Seven lower courts have uniformly rejected the specific claims raised in this case, while many more courts have uniformly rejected related claims. Review by this Court is not warranted.

II. Alternatively, the judgment of the court of appeals below should be affirmed. The district court correctly found that a 500mg dose of midazolam was

highly likely to render Petitioners unconscious and insensate for the duration of their executions. It is *not* undisputed that there is a "medical consensus" that a 500mg dose of midazolam cannot reliably put a person in a coma-like state. The record evidence indicates that a large dose of midazolam produces a level of unconsciousness sufficiently deep to render persons insensate to even extremely painful stimuli.

Petitioners' three objections to the use of midazolam are unavailing. First, midazolam's lack of analgesic properties – shared by sodium thiopental and pentobarbital – is irrelevant because after being administered the midazolam, Petitioners will be unconscious and insensate to pain. Second, the risk of paradoxical reactions to midazolam manifesting *after* Petitioners have been rendered unconscious is so low that Petitioners can point to only two reported incidents of such reactions in the decades-long history of midazolam's use. Third, Petitioners' claims concerning midazolam's "ceiling effect" amount to little more than theoretical speculation, since the dosage ceiling of midazolam has never been established and there is no evidence that any purported ceiling takes effect before a person is rendered deeply unconscious and insensate to noxious stimuli. Moreover, Oklahoma's robust procedural safeguards will eliminate any risk that Petitioners will experience severe pain during their executions. On these facts, Oklahoma's lethal injection protocol does not present a substantial risk of severe pain and cannot be considered cruel.

The district court also did not err in admitting the opinions of Oklahoma's expert, who Petitioners conceded was well-qualified and whose relevant opinions were never subject to a *Daubert* challenge. All of Petitioners' quibbles with Oklahoma's expert's opinions lack merit and the district court's reliance on that testimony – especially in view of the highly flawed testimony of Petitioners' experts – was not an abuse of discretion. Regardless, the Tenth Circuit gave Petitioners every benefit of the doubt, assuming the validity of Petitioners' disagreements with Oklahoma's expert testimony, but correctly determined that none of those issues undermined the scientific reliability of Oklahoma's evidence as relevant to the district court's factual findings.

III. Petitioners initially asked this Court to decide whether the *Baze* standard applied only to challenges to execution protocols "substantially similar" to the protocol addressed in *Baze*. By its own terms, *Baze* resolved all challenges to protocols "substantially similar" to the one challenged, then articulated the standard that governs challenges involving drug protocols that are *not* substantially similar.

Realizing that the issue presented for certiorari easily resolves in Oklahoma's favor, Petitioners now argue a different issue – that the Tenth Circuit applied too stringent a preliminary injunction standard. But the Tenth Circuit explicitly applied the "significant probability of success on the merits" standard that Petitioners request, and this Court cannot presume that the appeals court *sub silentio* applied a

different and more stringent standard. Furthermore, the district court concluded that, even applying a more relaxed preliminary injunction standard than the one requested by Petitioners here, Petitioners had failed to meet their burden for a stay.

Moreover, contrary to Petitioners' arguments, the *Baze* standard *should* apply to all stay requests. The plurality unequivocally held that "[a] stay of execution may not be granted on grounds such as those asserted here unless the condemned prisoner establishes that the State's lethal injection protocol creates a demonstrated risk of severe pain * * * [that] is substantial when compared to the known and available alternatives." That statement should be taken at face value.

IV. Finally, Petitioners challenge the Tenth Circuit's alternative holding – "not outcome-determinative in this case" – that interpreted *Baze* to require those challenging a method of execution demonstrate that an alternative method is available that will substantially lower the risk of severe pain as compared to the method challenged. Petitioners here did not make any such showing.

Petitioners contend that *Baze*'s alternatives requirement applies only to cases advocating an improved method in the place of a "concededly constitutional" one – which, if true, would exclude *Baze* itself. Rather, the *Baze* plurality explicitly set out to establish a broadly applicable standard in response to a concurring Justice's concern about insufficient guidance

on method-of-execution cases. Accordingly, all courts of appeals thus far agree that *Baze* applies to all challenges to a method of execution.

This Court requires Petitioners to demonstrate the availability of a constitutional alternative method of execution for good reason. Capital punishment is constitutional, and this Court has made clear that States must have a means of carrying it out, even if some pain results as an inescapable consequence of execution. Accordingly, challenges to a method of execution must demonstrate that there exists a feasible alternative method that will result in substantially less pain. Otherwise, a petitioner's challenge would constitute a challenge to the death penalty itself – an issue foreclosed by the Constitution.

ARGUMENT

I. THE PETITION SHOULD BE DISMISSED AS IMPROVIDENTLY GRANTED.

Petitioners ask the Court to reverse the detailed factual findings of a district court, affirmed by the court of appeals, which are based on the documentary record and the testimony of a concededly-qualified expert, as well as the district court's judgment that this expert testified more credibly than Petitioners' experts. The petition does not present a case that is appropriate for review by this Court, and it should be dismissed as improvidently granted.

Petitioners' primary contention is that the district court committed clear error, Pet. Br. 32-38, when it made the factual findings that, "[i]n the dosage called for by [Oklahoma's execution] protocol, midazolam * * * is highly likely to render the person unconscious and insensate during the remainder of the [execution] procedure." J.A.77. The Tenth Circuit, "[a]fter carefully examining the record on appeal," held that none of those factual findings are clearly erroneous. J.A.135-37. These same factual findings – based on the testimony of multiple experts, including the same dueling experts here – have been made by another federal district court and affirmed by another court of appeals, as well as by two state trial courts, both affirmed by that state's supreme court. See *Chavez*, 742 F.3d at 1270-73; *Howell*, 133 So.3d at 519-22; *Muhammad*, 132 So.3d at 188, 193-95.

As demonstrated below, "all of these challenges lack merit." J.A.128. Regardless, this Court is not in the practice of reviewing cases where "the asserted error consists of erroneous factual findings." S. Ct. R. 10. Not being "a court of correction of errors in fact finding," this Court is loathe "to review concurrent findings of fact by two courts below" – much less the factual findings of *seven* courts. *Exxon Co., USA* v. *Sofec, Inc.*, 517 U.S. 830, 841 (1996) (quoting *Graver Tank & Mfg. Co.* v. *Linde Air Products Co.*, 336 U.S. 271, 275 (1949)).

Petitioners also claim that the court of appeals applied the wrong standard in evaluating whether a stay should be granted, Pet. Br. 39-46, but ignore the fact that the Tenth Circuit explicitly *did* apply the standard Petitioners request. J.A.113, 120-22 & n.5, 138; see p.58, *infra*. To the extent that Petitioners are contending "the misapplication of a properly stated rule of law," review by this Court is also unwarranted. S. Ct. R. 10.

Finally, Petitioners challenge the Tenth Circuit's application of the second prong of the *Baze* test, requiring that challengers to a method of execution identify a substantially less painful and available alternative. Pet. Br. 46-52. But, as explicitly stated by the court below, this alternative holding "is not outcome-determinative in this case." J.A.130. This Court generally dismisses questions where the judgment below was resolved on other sufficient grounds. See, e.g., *Belcher* v. *Stengel*, 429 U.S. 118 (1976); *The Monrosa* v. *Carbon Black, Inc.*, 359 U.S. 180 (1959). Moreover, those courts of appeals that have addressed this issue are in unanimous agreement with the Tenth Circuit, see pp.61-62, *infra*, providing yet another reason why review is unwarranted or premature, see S. Ct. R. 10(a).

Capital litigation, especially at the preliminary injunction stage, is often an expedited exercise. This case is no exception: Oklahoma had one day to respond to the petition for a writ of certiorari and applications

for stays of execution, and the Court granted certiorari after this highly-compressed briefing schedule in less than two weeks. "Now that plenary consideration has shed more light on this case" and the Court has had a full opportunity to consider the merits, it is apparent that the petition presents no appropriate issues for resolution by this Court and should be dismissed as improvidently granted. *Belcher*, 429 U.S. at 119-20.

II. OKLAHOMA'S USE OF MIDAZOLAM DOES NOT CREATE A "SUBSTANTIAL RISK OF SERIOUS HARM" TO PETITIONERS.

From the firing squad, to electrocution, to lethal injection, "[t]his Court has never invalidated a State's chosen procedure for carrying out a sentence of death as the infliction of cruel and unusual punishment." *Baze*, 553 U.S. at 41-42, 47-49 (citations omitted). This Court has speculated that a method of execution could violate the Eighth Amendment if it inherently involves "torture or a lingering death," is "inhuman and barbarous," or was calculated to "superadd[ ]" "terror, pain, or disgrace" to the execution, reflecting a "deliberate infliction of pain for the sake of pain." *Id.* at 48-49 (citations omitted). In "attack[ing] the judgment of the representatives of the people," however, those challenging a method of execution bear a "heavy burden" to show the State's choice is "cruelly inhumane" in order to prevail on

an Eighth Amendment claim. *Gregg* v. *Georgia*, 428 U.S. 153, 175 (1976).

In *Baze*, this Court considered whether Kentucky's three-drug protocol for execution – the successive injection of sodium thiopental, pancuronium bromide, and potassium chloride – violated the Eighth Amendment. *Baze*, 553 U.S. at 44, 49. The Court upheld the protocol and held that a method of execution could be cruel and unusual if it "creates a substantial risk of serious harm" that is "objectively intolerable" and is "sure or very likely to cause * * * needless suffering" when compared to alternatives that are "feasible, readily implemented, and in fact significantly reduce a substantial risk of severe pain." *Id.* at 50-52.

Oklahoma's similar protocol does not expose Petitioners to "a substantial risk of severe pain" that would produce "torture or a lingering death." Petitioners' misapprehension of the law and misstatement of the facts notwithstanding, the courts below correctly found that the dose of midazolam called for in Oklahoma's protocol is "highly likely to render [Petitioners] unconscious and insensate" during their executions and therefore Petitioners had not demonstrated a substantial probability that Oklahoma's protocol presents "an objectively intolerable risk of harm" in violation of the Eighth Amendment. J.A.77, 96.

A. Oklahoma's Protocol Is Highly Likely To Render Petitioners Unconscious And Insensate To Severe Pain During Their Execution.

1. Midazolam is a potent sedative used by physicians to depress the central nervous system for the induction and maintenance of anesthesia. Midazolam's FDA Label warns that large doses of midazolam can produce coma and death. See also Tr.661. Midazolam induces anesthesia at doses from 0.1 to 0.4mg/kg (7 to 28mg for a 70kg person), causing unconsciousness and eliminating the brain's registration and awareness of pain. See pp.5-9, *supra*. Studies of midazolam indicate that, at a large dose, it can fully replace other drugs as a sole anesthetic. *Supra* n.1. At a bolus dose of 500mg, the State and the Petitioners' experts agreed that "midazolam would produce unconsciousness" at a level "render[ing] a prisoner insensate" to painful and noxious stimuli, like "setting a femoral IV line," which involves "digging deep[ ] into the tissue, * * * a couple of inches below the skin." J.A.77-78, 302; Tr.668.

Accordingly, the district court correctly found that, as used in Oklahoma's protocol, midazolam "is highly likely to render the person unconscious and insensate during the remainder of the [execution] procedure" and will "make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which could occur from the application of the second and third drugs." J.A.77. These factual findings are reviewed by this Court for clear error, *e.g.*, *Highmark* v. *Allcare*

Health Management System, Inc., 134 S. Ct. 1744, 1748 (2014), and on these facts, the district court and the court of appeals did not abuse their discretion in concluding that Petitioners failed to establish a likelihood of success on their Eighth Amendment claim.

2. Recognizing that there is little chance of overturning the district court's factfinding on clear-error review, Petitioners attempt to avoid the clear error standard on the ground that "the undisputed facts alone" establish an Eighth Amendment violation. Pet. Br. 28-32. Petitioners' transparent attempt to secure *de novo* review fails because Respondents (backed by the district court's factfinding) contest nearly all of the facts Petitioners allege, as well as the legal conclusions Petitioners draw from them.

Respondents maintain, and the district court found, that a 500mg dose of midazolam would reliably keep Petitioners unconscious and insensate throughout the execution. This fact alone renders Oklahoma's protocol constitutional.

Petitioners disregard this fact, arguing that *Baze* requires a "deep, coma-like unconsciousness" in order for the latter two drugs to be administered constitutionally – regardless of whether the condemned is unaware of pain or the amount of pain they experience. Pet. Br. 28-30. But the particular facts of *Baze* did not establish a constitutional floor for the three-drug protocol. While the Court concluded in *Baze* that any lethal injection protocol "substantially similar" to the one at issue there would be constitutional, the

Court did not conversely hold that only protocols that are "substantially similar" could survive Eighth Amendment scrutiny. *Baze*, 553 U.S. at 61.

The Court never held, and Oklahoma here has never conceded, that administration of the latter two drugs on someone not in a "deep, comalike unconsciousness" would in all instances violate the Constitution. A prisoner unaware or substantially unaware of the pain of the second or third drugs does not experience a constitutionally unacceptable level of pain, regardless of the exact depth of consciousness.[18]

Regardless, it is *not* undisputed, much less is there any medical consensus, that a 500mg dose of midazolam cannot reliably put a person in a comalike state. As noted above, the record evidence indicates that a large dose of midazolam causes a coma and produces unconsciousness sufficiently deep to render persons insensate to even extremely painful stimuli. The study cited by Petitioners' own expert

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[18] Even for patients not completely unconscious, midazolam "significantly reduce[s] * * * the pain experience." P. Coulthard & J.P. Rood, *An investigation of the effect of midazolam on the pain experience*, 30 Br. J. Oral & Maxillofacial Surgery 248 (1992). Thus, studies on humans seeking to determine the anesthetic effects of different dosages of midazolam involved reducing anesthesia during surgery until "movement occurred in response to surgical incision." Inagaki, *supra* n.1, at 614; Melvin, *supra* n.1, at 239. If the minimal awareness of that pain under the heavy anesthetic effects of midazolam is not too cruel for approved medical studies, it cannot violate the Eighth Amendment.

concluded that the dose used by Oklahoma would be sufficient to use as a sole surgical anesthetic. *Supra*, n.1.

B. The District Court Did Not Err By Relying On Oklahoma's Concededly-Qualified Expert Instead Of Petitioners' Expert.

1. Petitioners conceded that Oklahoma's expert was well-qualified to render expert opinions on the pharmacological effects of midazolam, and did not challenge the reliability of his opinions on this subject. J.A.34. Petitioners now belatedly argue that the district court erred by allowing Dr. Evans to offer expert opinions. Each of the criticisms levied at Dr. Evans are criticisms that could have been raised prior to the preliminary injunction hearing or could have been the subject of cross-examination by Petitioners' counsel, followed by an oral *Daubert* motion. Having not raised this challenge below, it is waived. *Macsenti* v. *Becker*, 237 F.3d 1223, 1230-34 (10th Cir. 2001), cert. denied, 533 U.S. 950 (2001); *Marbled Murrelet* v. *Babbitt*, 83 F.3d 1060, 1066-67 (9th Cir. 1996).

2. In any event, Petitioners' attacks on Dr. Evans do not undermine the reliability of his testimony. *First*, any opinion as to the effect of a 500mg dose of midazolam necessarily must be extrapolated from known information about lower doses because,

as Petitioners' expert acknowledged, "no one is ever given doses like this," since they are likely to be lethal to a patient or clinical subject. Tr.145; J.A.176. Because Midazolam is commonly used to induce unconsciousness during painful procedures, even Petitioners' expert opined that a 500mg dose would produce unconsciousness. J.A.77, 212. Extrapolations are used in the studies Petitioners' expert cites. Hall, n.1, *supra*. Further, the sparse medical literature on the subject does not establish a "ceiling effect" for midazolam but merely speculates about its potential existence. P.53, *infra*.

Second, Dr. Evans' extrapolations were not based on "an egregious mathematical error." Pet. Br. 35-36. Dr. Evans' expert report contains the correct lowest toxic dose of around 0.07mg/kg, which both parties' experts agreed upon, J.A.217, and which is about 100 times less than a 500mg dose for a 70kg person. *Supra* n.16. Deaths caused by midazolam, far from "unsubstantiated anecdotes," Pet. Br. 35, are well documented in the medical literature. *Supra* n.13. The only unsubstantiated testimony on this subject is Petitioners' expert's less-than-believable assertion that these dozens of reported deaths only occurred in patients who were nearly a century old, had heart failure, and were improperly administered the drug, Pet. Br. 35 (citing J.A.217), which is contradicted by Midazolam's FDA Label with a warning of

"life-threatening" effects applying "regardless of age or health status."[19]

Third, Petitioners' criticism of the shorthand way in which Dr. Evans orally described the actions of midazolam to a lay court are contrived, at best. "The most widely accepted hypothesis" for midazolam's mechanism of action is that midazolam (1) attaches to GABA receptors and (2) "interferes with reuptake of GABA, thereby causing accumulation of GABA," both of which result in central nervous system depression. Inagaki, *supra* n.1, at 616; see also Cheng, *supra*, at 44 ("Midazolam action can therefore be attributed to inhibition of GABA uptake."). Dr. Evans testified, in shorthand terms, that midazolam works in two ways: (1) "Midazolam attaches to GABA receptors," as well as (2) "inhibiting GABA." J.A.293, 312-13. Not surprisingly, Dr. Evans' testimony on this point did not draw a single question on cross-examination. At worst, Dr. Evans' testimony can be criticized for being "unclear," as stated by Petitioners' expert in his after-the-fact declaration. J.A.281. In any event, none of

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[19] Petitioners also criticize Dr. Evans' reliance on drugs.com but, notably, do not question the accuracy of any of the information contained therein. Cf. J.A.325-26. Drugs.com states that it "provides accurate and independent information," but contains a *consumer* disclaimer that is present in nearly every medical publication, including journals upon which Petitioners' experts rely. See, e.g., Anesthesiology, Terms and Conditions of Use, http://anesthesiology.pubs.asahq.org/ss/terms.aspx ("None of the information on this Site shall be used to diagnose or treat any health problem or disease.").

the purported mistakes made by Dr. Evans – and they are not mistakes – were relied upon by in the district court's or the court of appeals' review of those findings. J.A.75, 134-37.

Petitioners also ignore that the district court did not reach its factual findings in a vacuum: the court also had before it the testimony of Petitioners' expert, Dr. Lubarsky, which was so riddled with speculation, unsubstantiated claims, and internal contradiction that the district court did not clearly err in crediting Dr. Evans' testimony over Dr. Lubarsky's. See *Anderson* v. *Bessemer City*, 470 U.S. 564, 575 (1985) ("when a trial judge's finding is based on his decision to credit the testimony of one of two or more witnesses, * * * that finding, if not internally inconsistent, can virtually never be clear error"). As noted above, Dr. Lubarsky's testimony on the limited lethal toxicity is wholly unsubstantiated and contradicted by the record. Also left unsupported was his claim of reports of paradoxical effects occurring after sedation. P.23, *supra*. His unsupported claim that pentobarbital is approved as a sole anesthetic is contradicted by the drug's label. *Ibid.* His testimony on midazolam's anesthetic capabilities contradicted the testimony of Petitioners' other expert and even his own testimony. Pp.24-25. Dr. Lubarsky also testified, incredibly, that *sodium thiopental* was "insufficient to render a patient unconscious through the entirety of the execution" and its use was "constructed to produce egregious harm and suffering" – a claim that not even the petitioners faced with impending death in

Baze were willing to make. J.A.226-27. And his reports and declarations consistently misconstrue medical literature. Pp.22-23.

Scholars, as well as members of this Court, have criticized Lubarsky's claims regarding lethal injection drugs. Pp.18-19, *supra*. Courts have consistently rejected Dr. Lubarsky's testimony regarding the anesthetic effects of drugs used in lethal injections, including midazolam. See, e.g., *Chavez*, 742 F.3d at 1269-73; *Howell*, 133 So.3d at 518-22; *West* v. *Schofield*, 380 SW.3d 105, 114-16 (Tenn. 2012); *Brown* v. *Crawford*, 408 F.3d 1027 (8th Cir. 2005). The district court did not clearly err in doing the same.

C. Petitioners' Speculative Criticisms Of Midazolam Do Not Establish That Its Use Puts Them At Substantial Risk Of Serious Harm.

The criticisms Petitioners level at midazolam are largely similar to those leveled at sodium thiopental and pentobarbital, and which were ultimately proven to be nothing but speculations: that midazolam (1) is not an analgesic, (2) can cause paradoxical reactions, and (3) has a ceiling effect.

1. Midazolam's analgesia has no relevance to whether it can render an inmate unconscious and unaware of pain.

Midazolam is not considered to be an analgesic. Neither are sodium thiopental and pentobarbital. See, e.g., DailyMed, *Label: Thiopental Sodium – thiopental sodium injection, powder, for solution* (Feb. 2011), 1.usa.gov/1bPLDbM; *United States* v. *Turner*, 38 C.M.R. 757, 759 (N.B.R. 1968), *reversed on other grounds*, 39 C.M.R. 55 (C.M.A. 1968). That lack of analgesia has never had any impact on this and other courts' determinations that sodium thiopental and pentobarbital were constitutionally-sound choices as the first drug in three-drug protocols. In *Baze*, for example, Petitioners' expert witness testified that sodium thiopental was not an analgesic and suggested that it in fact had anti-analgesic effects. Joint Appendix vol. II, *Baze* v. *Rees*, No. 07-5439, 2007 WL 4790797, *434-35. None of the opinions rendered in the case mentioned analgesia as a factor relevant to the Eighth Amendment analysis.

Midazolam's lack of analgesic qualities has no bearing on its effectiveness in rendering Petitioners unconscious and insensate. As the district court correctly found, pain relief is only necessary for a patient who is aware of pain in the first instance. When the patient is unconscious and unaware of pain, there is no need for analgesia. J.A.77, 314-15; see also Pet. Br. 3 (acknowledging barbiturates "eliminate the risk that a prisoner will feel pain," though they too are not

analgesics); *Howell*, *supra* n.2, IX Supp.R. at 217-19 (when unconscious under midazolam, a person is "oblivious to all external stimuli" and unable to "consciously process" pain). And unlike surgeries, where analgesia is helpful in reducing the pain the patient will feel upon awakening, in a lethal injection, there is no similar need for analgesia.

2. The risk of paradoxical effects from midazolam does not pose a substantial risk of pain.

In a very small percentage of cases, paradoxical reactions occur with benzodiazepines, J.A.78, just as they do with other drugs – even barbiturates like pentobarbital, see, e.g., J. Hayden, Jr. et al., *Paradoxical Reaction to Intravenous Pentobarbital, Meperidine, and Scopolamine*, 21 Anesthesia Progress 82, 82-83 (1974). In these instances, rather than rendering the recipients unconscious, midazolam causes them to become agitated and even combative. J.A.172-73. This *slight* chance of a paradoxical reaction does not create a *substantial* risk that Petitioners will not be unconscious when the second and third drugs are administered. J.A.78-79.

If a paradoxical reaction is occurring, Oklahoma's use of trained medical personnel – here, a physician and a paramedic, both highly-qualified and trained – to monitor the administration of midazolam ensures that the inmate will never be declared unconscious,

and the second and third drugs will never be administered. Pp.16-17, *supra*; Tr.374-75.

Petitioners could point to only two case reports of paradoxical reactions manifesting after midazolam sedations – reactions to low doses which did not result in any pain awareness – out of the tens of millions of administrations of midazolam that have occurred over the past several decades. See pp.25-26, *supra*. Petitioners' expert claimed to have overseen a million administrations of midazolam, yet never claimed to have witnessed such a late-manifesting reaction. A two-in-many-millions chance does not a "substantial risk" make.

3. Petitioners failed to present any evidence that midazolam has a ceiling effect that would prevent a 500mg dose from rendering them unconscious and insensate to pain.

Petitioners claim midazolam is subject to a "ceiling effect" and, as a result, "[t]he medical consensus is that midazolam cannot generate deep, comalike unconsciousness." Pet. Br. 26. Yet, even if midazolam does produce a ceiling effect, the legally relevant question is whether that effect impacts midazolam's ability to render the recipient unconscious and insensate. And, the medical consensus is clear on this issue, as evidenced by Midazolam's FDA Label, which warns that a larger-than-therapeutic dose can result in coma and death, p.5, *supra*, an effect much greater

than that needed to comply with the Eighth Amendment bar on cruel and unusual punishment.

The sources that Petitioners' expert relied upon – in a declaration submitted to the court of appeals and never presented to the district court – merely hypothesize that there *might* be a ceiling effect with midazolam, though no testing ever established that "ceiling." *Supra*, n.14. One study actually described the dosage at which midazolam could serve as a sole anesthetic. *Ibid.* When pressed, Petitioners' expert admitted he could not render an opinion as to the dosage at which this alleged ceiling was reached. J.A.225.

It is unsurprising that the district court concluded that Petitioners' evidence on this point failed to establish a probability of success on the merits. Petitioners' evidence was speculative at best. J.A.94-96, 99 (citing *Brewer* v. *Landrigan*, 131 S. Ct. 445 (2010)).

By contrast, Oklahoma's expert offered persuasive testimony that was consistent with both the FDA's findings and testimony of several other experts in litigation in Florida. For example, consistent with Midazolam's FDA Label, Dr. Evans testified that a large dose of midazolam would induce a coma. Tr.661. Dr. Mark Dershwitz, an expert anesthesiologist who has published research on midazolam, testified in Florida that "a 500 mg dose of midazolam places the recipient in a coma," which the court accepted while rejecting Dr. Lubarsky's testimony. *Howell*, 133 So.3d

at 521.[20] In separate Florida litigation, Dr. Mark Heath, *an expert testifying for the condemned*, "agreed that the dosage of midazolam hydrochloride called for in the protocol, if properly administered together with adherence to the procedures for determining consciousness, will result in an individual who is deeply unconscious and who would feel no pain when the remaining drugs are administered." *Muhammad*, 132 So.3d at 195; see also *id.* at 193-94 (noting testimony by Dr. Heath that midazolam "will have full efficacy as an anesthetic" such that even a 10 or 15mg dose "will reliably produce a much deeper level of unconsciousness" and a 500mg dose "is a much larger dose than that needed to produce unconsciousness and * * * would, with certainty, produce death"). The district court properly credited Oklahoma's evidence over Petitioners' evidence.

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[20] When contrasting Dr. Lubarsky's conjectural testimony with that of Dr. Dershwitz, the Florida Supreme Court noted that, "when asked questions as to the effects of 500 mg on a person, Dr. Lubarsky had to speculate as to the results." *Howell*, 133 So.3d at 522. By contrast, Dr. Dershwitz used midazolam as "the first and primary drug to induce anesthesia" in neurosurgeries and testified based on his direct experience that "where a 50 mg dose prevented his patients from perceiving the noxious stimuli associated with neurosurgery, [ ] it was clear a 500 mg dose would prevent the recipient from being 'able to perceive any noxious stimuli whatsoever.'" *Ibid.*

4. Oklahoma's robust procedural safeguards obviate the risk of insufficient anesthesia.

Petitioners have no complaints with the procedural safeguards Oklahoma has employed to ensure proper administration of the drug protocol and to determine and monitor unconsciousness.

Rightly so. Oklahoma's revamped execution procedures address each and every procedural concern raised in *Baze*. For example, the dissent in *Baze* suggested that (1) medical personnel monitor the inmate's face and IV point on closed circuit television; (2) medical personnel physically confirm the inmate's unconsciousness, through medically appropriate means, like brushing the inmate's eyelids, shaking the inmate, saying the inmate's name, and applying noxious stimuli; (3) a mandatory amount of time be allowed to elapse after administration of the first drug, and prior to the administration of the second and third drugs; and (4) the use of an EKG to monitor unconsciousness. *Baze*, 553 U.S. at 120 (Ginsburg, J., dissenting). The plurality held that Kentucky's execution protocol did not create a substantial risk of serious harm despite not having any of these safeguards. See *id.* at 54-56. Oklahoma's execution protocol has *all* of them. J.A.63-66; Execution Protocol 43 (Doc. 117-2).

Oklahoma's procedural safeguards are relevant. In *Baze*, the claim was that deficiencies in Kentucky's procedural safeguards could be obviated by a change

in drug protocol. The converse is also true. An alleged deficiency in a drug protocol can be obviated by robust procedural safeguards. Both the drug and procedural protocols lower the risk of pain. The district court accordingly found highly relevant three parts of the revised lethal injection protocol: (1) "both primary and backup IV access sites be established"; (2) "viability of the IV sites" be confirmed; and (3) "the offender's level of consciousness [] be monitored throughout the procedure." J.A.97. Indeed, these three safeguards, in addition to all the other safeguards utilized by Oklahoma – for example, the use of highly-trained medical personnel – fully mitigate any alleged risk of pain that might arise from use of midazolam.

* * *

Much like the attacks leveled at sodium thiopental and pentobarbital, which turned out to be unwarranted after both drugs established a solid record of reliably rendering inmates deeply unconscious, the attacks leveled at midazolam here are unwarranted.

Oklahoma has already conducted an execution using the drug protocol at issue here. The execution was completed without incident, and, by all accounts, the midazolam worked exactly as intended. Pp.32-33, *supra*. There was no paradoxical reaction, no "ceiling effect" that prevented the midazolam from rendering the inmate deeply unconscious, and no need for analgesia because the inmate was deeply unconscious. Likewise, the eleven executions carried out by

Florida using an identical protocol establish that a 500mg intravenous dose of midazolam reliably renders the inmates deeply unconscious and unaware of pain. Neither the district court nor the court of appeals abused their discretion in upholding Oklahoma's execution protocol.

III. PETITIONERS FAILED TO SATISFY EVEN THE MOST RELAXED OF PRELIMINARY INJUNCTION STANDARDS.

Petitioners' second question presented asks whether the *Baze* standard applies to challenges of drug protocols not substantially similar to the one at issue in *Baze*. Every court of appeals that has considered this issue has concluded that it does so apply, pp.61-62, *infra*, and correctly so.

The standard set forth by the *Baze* plurality mandates that "[a] stay of execution may not be granted on grounds such as those asserted here unless the condemned prisoner establishes that the State's lethal injection protocol creates a demonstrated risk of severe pain * * * [that] is substantial when compared to the known and available alternatives." *Baze*, 553 U.S. at 61. Critically, the next line in the opinion explains that "[a] State with a lethal injection protocol substantially similar to the protocol we uphold today would not create a risk that meets this standard." *Id.* Because the Court blessed all "substantially similar" protocols, the standard articulated by the Court was necessarily intended for

application to *dis*similar protocols. Thus, the answer to the second question presented is a straightforward "yes," and there is no good reason to set aside the circuit courts' consensus on this point.

Unsurprisingly, then, Petitioners have transformed that question into something altogether different and new: whether the Tenth Circuit applied the wrong preliminary injunction standard. Even on this question, on which this Court has not granted certiorari, Petitioners are incorrect.

1. The court of appeals explicitly applied the "significant probability of success on the merits" standard articulated by this Court in *Hill* v. *McDonough*, 547 U.S. 573, 584 (2006). J.A.121 n.5 (rejecting the standard proposed by Petitioners in favor of the *Hill* standard); see also J.A.113, 120, 138. The court of appeals should be taken at its word. This Court has long been deferential to lower courts with regard to whether they applied proper standards of review. See, e.g., *Wainwright* v. *Witt*, 469 U.S. 412, 431 (1985) (holding that a trial court is presumed to have applied the correct standard, even in cases where the record is silent as to what standard was applied).

2. Petitioners point to the Tenth Circuit's description of the *Baze* standard as their evidence that it *sub silentio* substituted that standard in place of the preliminary injunction standard. Pet. Br. 39. But in order to properly apply the "significant probability of success on the merits," a court must first *define* success on the merits. Only by doing so can the court

accurately measure whether the movant has made the requisite "clear showing" that he has a significant probability of success. *Hill*, 547 U.S. at 584 (citing *Mazurek* v. *Armstrong*, 520 U.S. 968, 972 (1997)). Placing this burden on the movant is critical, because "a stay of execution is an equitable remedy" that is "not available as a matter of right," and "equity must be sensitive to the State's strong interest in enforcing its criminal judgments without undue interference from the federal courts." *Ibid.*

3. In any event, the district court heard three days of testimony, made credibility determinations, and weighed the evidence when determining that Petitioners had not made that clear showing of a significant probability of success. J.A.41. The district court went one step further and held that Petitioners had failed to meet even the more relaxed standard that the Tenth Circuit applies when a movant has satisfied the other three prongs of the preliminary injunction test: whether Petitioners had "raised questions going to the merits so serious, substantial, difficult and doubtful, as to make them a fair ground for litigation." J.A.41 (citing *Kikumura* v. *Hurley*, 242 F.3d 950, 955 (10th Cir. 2001)). In other words, no matter the standard, Petitioners failed to meet it.

4. While ultimately beside the point here, the *Baze* standard *should* in fact apply to all requests for a stay "on grounds such as those" asserted there. The *Baze* plurality articulated its standard of when "[a] stay of execution may not be granted" in answer to Justice Stevens' criticism that the "opinion leaves the

disposition of *other* cases uncertain," *Baze*, 553 U.S. at 61 (emphasis added), thus speaking to future cases like this one. *Baze* applies any time a stay of execution is requested.

Petitioners argue that their case is distinct from *Baze* in that the *Baze* petitioners conceded that the "State's method, if administered according to plan, would be constitutional." J.A.27. Hardly so. There, as here, the petitioners claimed that the State's chosen drug protocol was *inherently* unconstitutional because it was *impossible* for Kentucky to administer it in a way that did not place them at risk of pain. Compare Pet. Br. 27 with Reply Br. for Pet'rs, *Baze* v. *Rees*, 2007 WL 4618321, *1 ("Kentucky has built into its execution procedures an inherent danger of inflicting excruciating pain upon condemned prisoners."). Because Petitioners' claims challenge a method of execution – "grounds like those" asserted in *Baze* – a "stay of execution may not be granted" unless they satisfy the *Baze* standard. *Id.* at 61.

IV. PETITIONERS FAILED TO SHOW THAT ANY RISK WOULD BE SUBSTANTIAL AS COMPARED TO AVAILABLE ALTERNATIVES.

Baze holds that, after making a threshold showing of a "demonstrated risk of severe pain," the prisoner "must show that the risk is substantial *when compared to the known and available alternatives*" to succeed on an Eighth Amendment challenge to a

method of execution. *Baze*, 553 U.S. at 61. The Tenth Circuit resolved the case at the first step of the inquiry, finding it "not even 'necessary in this case to reach the second step of the *Baze* test,'" but nonetheless correctly noted that Petitioners' failure to identify a single "known and available alternative" provided a second, independent basis for rejecting Petitioners' claim. J.A.130 & n.9 (citation omitted). Petitioners challenge this alternative holding, arguing that *Baze*'s second step applies only to challenges seeking "to force the State to adopt a substantially improved method in lieu of its concededly constitutional method." Pet. Br. 50.

1. Contrary to Petitioners' characterizations, *Baze* did not involve a challenge to a "concededly constitutional method." P.60, *supra*. Not surprisingly, every Circuit that has considered the issue has endorsed the Tenth Circuit's straightforward reading of *Baze* as the standard for *all* cases challenging methods of execution, not just those seeking to substitute a concededly-constitutional method. See, e.g., *Zink* v. *Lombardi*, ___ F.3d ___, 2015 WL 968176, *8-10 (8th Cir. Mar. 6, 2015) (en banc); *Whitaker* v. *Livingston*, 732 F.3d 465, 468 (5th Cir. 2013); *Mann* v. *Palmer*, 713 F.3d 1306, 1315 (11th Cir. 2013); *Jackson* v. *Danberg*, 656 F.3d 157, 163-65 (3d Cir. 2011); *Pavatt* v. *Jones*, 627 F.3d 1336, 1339 (10th Cir. 2010); *Cooey* v. *Strickland*, 589 F.3d 210, 220 (6th Cir. 2009); see also *Chavez*, 742 F.3d at 1273-74 (Carnes, C.J., concurring) (stating, in case challenging use of midazolam, "[t]he Court could not have been clearer" that

"the inmate must prove * * * that there is a 'known and available alternative'" as an "element of a claim" under the Eighth Amendment).

Thus, the Tenth Circuit was correct to join its sister courts in holding that the *Baze* standard was "intended to apply to all challenges to 'a State's chosen procedure for carrying out a sentence of death.'" J.A.131 (quoting *Baze*, 553 U.S. at 48); see also *Baze*, 553 U.S. at 70 (Alito, J., concurring) ("The issue presented in this case" is "the constitutionality of a *method* of execution."); *Zink*, 2015 WL 968176 at *8-10; J.A.89-91. Indeed, the *Baze* plurality explicitly articulated its intention to apply this standard to a broad class of cases, *Baze*, 553 U.S. at 61, in direct response to Justice Stevens' concern that the holding would provide insufficient guidance on other cases concerning "lethal injection as a method of execution," *id.* at 71. See also *id.* at 102-03, 106 (Thomas, J., concurring) (recognizing that the plurality adopted a comparative standard for all Eighth Amendment claims); *id.* at 116 (Ginsburg, J., dissenting) (stating that, in challenges to methods of execution, the "availability of alternatives must be considered"); *id.* at 107-08 (Breyer, J., concurring) (same).

2. *Baze*'s requirement that challengers to an execution method identify a less painful and available alternative flows directly from this Court's longstanding Eighth Amendment jurisprudence. "We begin with the principle * * * that capital punishment is

constitutional." *Baze*, 553 U.S. at 47 (citing *Gregg*, 428 U.S. at 177). "It necessarily follows that there must be a means of carrying it out," even if "[s]ome risk of pain is inherent in any method of execution." *Baze*, 553 U.S. at 47.

An Eighth Amendment challenge to a method of execution that fails to identify an available alternative necessarily challenges as cruel and unusual the pain inflicted "as an inescapable consequence of death" – a challenge to the death penalty itself. *Baze*, 553 U.S. at 50. Accordingly, the *Baze* standard correctly requires petitioners challenging a method of execution – but not capital punishment itself – to demonstrate an available alternative lest a State's constitutional prerogative to provide for capital punishment be abrogated by having its chosen form of execution declared unconstitutional without any alternative to effectuate its laws. See *id.* at 61 ("The power of a State to pass laws means little if the State cannot enforce them." (quoting *McCleskey* v. *Zant*, 499 U.S. 467, 491 (1991))); *Baze*, 553 U.S. at 64 (Alito, J., concurring) ("Since we assume for present purposes that lethal injection is constitutional, the use of that method by the Federal Government and the States must not be blocked by procedural requirements that cannot practicably be satisfied.").

Petitioners complain that the *Baze* standard could make the constitutionality of an execution method hinge on the decisions of third parties, Pet. Br. 52, such as the decisions of death penalty opponents to

deprive States of the drug that make execution painless. But, as demonstrated above, that is the logical and necessary result of the Constitution's endorsement of capital punishment and a consequence recognized by the *Baze* plurality. *Baze*, 553 U.S. at 59-60; see also *id.* at 64-66 (Alito, J., concurring) (recognizing that challenge to method of execution based on lack of physician supervision is foreclosed by professional society's ethics rules prohibiting that supervision); *id.* at 112 (Breyer, J., concurring) (same).

3. None of this Court's decisions, before or after *Baze*, are to the contrary. Unlike *Baze*, *Hill* did not purport to rule on the elements necessary to prove a method of execution is cruel and unusual under the Eighth Amendment. Rather, the question in *Hill* was whether such a challenge "must be brought by an action for a writ of habeas corpus * * * or whether it may proceed as an action for relief under" Section 1983. *Hill*, 547 U.S. at 576. In examining "the legal distinction between habeas corpus" and claims under Section 1983, the Court held that Section 1983 itself did not impose "heightened pleading requirements" above those provided for in Rule 8. *Id.* at 581-82. Accordingly, a plaintiff need not plead an acceptable alternative in a Section 1983 suit, unless he is required to plead it as an element of proving an Eighth

Amendment challenge in other contexts, such as habeas corpus. *Ibid.*[21]

Jones v. *Bock* underscores this point. 549 U.S. 199 (2007). There, the question was whether the Prisoner Litigation Reform Act, which requires exhaustion of administrative remedies, mandated dismissal of a Section 1983 complaint that failed to plead exhaustion. *Id.* at 204. Starting with the noncontroversial proposition that Section 1983 itself did not require exhaustion, the Court next looked to the Act, to see whether Congress treated exhaustion as an element of the claim, or as an affirmative defense. *Id.* at 212. Concluding that the Act "does not itself require plaintiffs to plead exhaustion," the Court held that, "the usual practice" of treating exhaustion as an affirmative defense should be followed, and therefore it need not be pleaded. *Id.* at 212, 217.

After *Baze*, the Eighth Amendment "itself requires plaintiffs to plead" an available alternative form of execution when challenging a method of execution. Not surprisingly, then, *Baze* never mentioned *Hill* because those decisions addressed two entirely

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[21] Indeed, "Hill concede[d] that 'other methods of lethal injection * * * would be constitutional' " such that "Hill's action if successful would not necessarily prevent the State from executing him." *Hill*, 547 U.S. at 580. Whether on consideration of the merits the State would challenge this allegation and whether Hill would be able to prove availability had remained to be seen. *Id.* at 585. Here, Petitioners have not made any showing that any available and authorized alternative form of execution could be implemented. J.A.428.

separate questions, with the former concerning the elements of an Eighth Amendment claim and the latter focusing on the pleading standards imposed by Section 1983.

Thus, as the en banc Eighth Circuit correctly observed, "*Hill* did not address the elements of a successful claim under the Eighth Amendment," but rather "concerned only the *cognizability* of a complaint" under Section 1983 rather than habeas. *Zink*, 2015 WL 968176 at *10. "Whether Hill's complaint stated a claim for relief under Rule 8 and the Eighth Amendment is a question that 'goes to the merits' of the underlying action" and a question that was not addressed until *Baze* set forth "the elements of a claim challenging a lethal-injection protocol," including the necessity of demonstrating an available constitutional alternative. *Ibid.* (quoting *Bond* v. *United States*, 131 S. Ct. 2355, 2362 (2011)). Indeed, in *Nelson*, on which *Hill* primarily relied, this Court noted that "[i]f on remand and after an evidentiary hearing the District Court concludes that use of the [challenged] procedure * * * is necessary for administering the lethal injection, the District Court will need to address the broader question, *left open here*, of how to treat method-of-execution claims generally." *Nelson* v. *Campbell*, 541 U.S. 637, 646 (2004) (emphasis added).

CONCLUSION

The petition should either be dismissed as improvidently granted, or the judgment of the Tenth Circuit should be affirmed.

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APPENDIX

APPENDIX

The Eighth Amendment to the United States Constitution provides, in relevant part, that "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const. amend. VIII.

Title 42, section 1983, of the United States Code states that "[e]very person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress." 42 U.S.C. § 1983.

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IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

REPLY BRIEF FOR PETITIONERS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
REPLY BRIEF FOR PETITIONERS	1
I. THE PETITION SHOULD NOT BE DISMISSED	1
II. MIDAZOLAM CANNOT RELIABLY PREVENT PRISONERS FROM EXPERIENCING THE SUFFOCATION AND PAIN OF A PARALYTIC AND POTASSIUM CHLORIDE	4
A. A Benzodiazepine That Is "Not Anesthesia" Cannot Serve As The Sole Anesthetic In A Three-Drug Lethal Injection	4
B. The District Court's Findings About Midazolam Were Clearly Erroneous	9
III. PETITIONERS ARE ENTITLED TO A STAY OF EXECUTION FOR HAVING SHOWN A SIGNIFICANT POSSIBILITY OF SUCCESS ON THE MERITS	16
IV. THE EIGHTH AMENDMENT DOES NOT REQUIRE PETITIONERS TO REMEDY A STATE'S UNCONSTITUTIONAL ACT	17
CONCLUSION	22

TABLE OF AUTHORITIES

Page(s)

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Anderson v. *City of Bessemer City*, 470 U.S. 564 (1985) 11, 15
Barefoot v. *Estelle*, 463 U.S. 880 (1983), *superseded on other grounds by statute*, 28 U.S.C. § 2253 3
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Ex parte Milligan, 71 U.S. 2 (1866) 19
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Ex. C of Verified Compl., *Muhammad* v. *Crews*, No. 3:13-cv-1587 (M.D. Fla. Dec. 23, 2013), ECF No. 1–3 10

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Sup. Ct. R. 10(c) 1

REPLY BRIEF FOR PETITIONERS

Oklahoma may not execute petitioners with a paralytic drug and potassium chloride unless it can reliably prevent petitioners from feeling the suffocation and pain that those drugs concededly cause. Midazolam cannot serve that purpose. Respondents do not point to any scientific or medical consensus that midazolam alone reliably prevents a person from experiencing significant pain. Absent such consensus, lethal injection using a paralytic and potassium chloride poses a risk of harm that is objectively intolerable.

Respondents also urge the Court not to reach the merits. But the question whether midazolam, a drug that is "not anesthesia," poses an objectively intolerable risk of harm under the Eighth Amendment is an important question of law that this Court can and should resolve now. Despite citing two dozen sources not mentioned in the proceedings before the district court, respondents fail to identify a single study establishing that large doses of midazolam reliably cause comalike unconsciousness. Respondents also offer no reason why the Constitution requires a prisoner to cure the defects in a state's lethal injection protocol or accept an unconstitutionally cruel death.

I. THE PETITION SHOULD NOT BE DISMISSED.

Whether the Eighth Amendment permits states to administer constitutionally intolerable drugs without reliable anesthesia is a question of law that "should be[] settled by this Court." Sup. Ct. R. 10(c). That question has been fully briefed and is ripe for this Court's review. And it should be decided now, before

petitioners are subjected to a constitutionally unacceptable execution.[1]

1. In arguing that the petition was improvidently granted, respondents characterize "[p]etitioners' primary contention [as one asserting] that the district court committed clear error." Resp. Br. 38. But petitioners' primary contention is that, on the undisputed facts alone, relying on an unquantifiably riskier drug that is "not anesthesia," J.A. 78–79, to protect a prisoner against the grave harms inflicted by the second and third drugs poses the sort of "substantial" and "objectively intolerable" risks the Eighth Amendment forbids. *Baze* v. *Rees*, 553 U.S. 35, 50 (2008). Because the district court misapplied Eighth Amendment jurisprudence to the undisputed facts—which show that midazolam poses "greater risks" of pain than any other first drug previously used in a three-drug protocol, J.A. 78–79—this Court need not reach the issue of the district court's factual error. But in all events, on a question of constitutional importance—and one that district courts often decide under intense time pressure—clear error is no obstacle to this Court's review. See, *e.g.*, *Miller* v. *Fenton*, 474 U.S. 104, 116

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[1] Respondents argue that Oklahoma "extensively revamped" its execution facility and its procedures, Resp. Br. 16–17, and that this will prevent any further episodes like the gruesome execution of Clayton Lockett because a "deficiency in a drug protocol can be obviated by robust procedural safeguards," Resp. Br. 55–56. But respondents identify no procedural safeguard that cures midazolam's fundamental pharmacological inability to be anesthesia, nor do they address or even acknowledge that the use of the paralytic as the second drug will likely mask any pain caused by the revamped protocol. As an *amicus* brief filed on behalf of former state attorneys general points out, Oklahoma's recent revamping will not prevent another execution like Lockett's from occurring again. *See* Former State Attorneys General *Amicus* Br. 14–17.

(1985); *Bose Corp.* v. *Consumers Union of U.S., Inc.*, 466 U.S. 485, 510–11 (1984). That is especially the case where, as here, the errors that occurred were "obvious and exceptional." *Comcast Corp.* v. *Behrend*, 133 S. Ct. 1426, 1433 n.5 (2013) (rejecting contention that conclusions drawn from an expert's views were themselves "questions of fact" subject to clear error review and that petition was improvidently granted, explaining that, "even if it were a question of fact, [the conclusions were] . 'obvious[ly] and exceptional[ly]' erroneous").

2. The issue of whether *Baze* erected a higher standard for obtaining a stay of execution than that set forth in *Hill* v. *McDonough*, 547 U.S. 573, 584 (2006), and *Barefoot* v. *Estelle*, 463 U.S. 880, 895–96 (1983), *superseded on other grounds by statute*, 28 U.S.C. § 2253, is an important and recurring issue of law that drove the decision below, see J.A. 130, and one that only this Court can definitively address. The same is true regarding the question of whether prisoners must bear the burden of proposing an alternative to an unconstitutional method of execution. Although these issues were "not outcome-determinative" here, Resp. Br. 39 (quoting J.A. 130), they would necessarily be reached if the law were correctly applied to the facts and, given the gravity of capital punishment and the abbreviated review periods that courts face, warrant this Court's review.

II. MIDAZOLAM CANNOT RELIABLY PREVENT PRISONERS FROM EXPERIENCING THE SUFFOCATION AND PAIN OF A PARALYTIC AND POTASSIUM CHLORIDE.

A. A Benzodiazepine That Is "Not Anesthesia" Cannot Serve As The Sole Anesthetic In A Three-Drug Lethal Injection.

Petitioners present a threshold question of law that this Court can review de novo without addressing the district court's clear error: whether lethal injection using constitutionally intolerable drugs becomes permissible under the Eighth Amendment if the prisoner is first injected with midazolam. Two undisputed facts alone warrant reversal here: (1) the district court found that midazolam is not anesthesia and poses an unquantifiably greater risk of harm than the barbiturates previously used for this purpose, and (2) there is no medical consensus that midazolam reliably causes and maintains unconsciousness during painful procedures.

1. The district court erred as a matter of law by holding that the Eighth Amendment's prohibition against "substantial" or "objectively intolerable" risks of serious harm can be satisfied by a drug whose risk is unquantifiably "greater" than that presented by the constitutionally acceptable use of barbiturates. The district court found that "as opposed to pentobarbital or sodium thiopental" midazolam plainly presented an "added element of risk of pain." J.A. 79. The court was unable to estimate the magnitude of that danger, finding that "nobody knows" "[h]ow much greater that risk is." *Id.*

Respondents rely heavily on the district court's finding that a 500 mg dose of midazolam would, through a "phenomenon" that is "not anesthesia,"

J.A. 78, make it a "virtual certainty" or "highly likely" that a person would remain insensate throughout a painful execution, J.A. 125; see Resp. Br. 33–34, 42. A drug that carries an unquantifiably "greater" risk of not causing deep comalike unconsciousness cannot, at the same time, also be "virtually certain" to have that effect. It is objectively intolerable to rely on an unquantifiably risky drug that is "not anesthesia" as the sole anesthetic in an otherwise unconstitutionally painful lethal injection. *Baze*, 553 U.S. at 50, 53. Respondents do not and cannot reconcile the district court's internally inconsistent findings, and this inconsistency alone warrants reversal.

2. In *Baze*, there was a medical consensus that sodium thiopental produces "'deep, comalike unconsciousness,'" Pet. Br. 30 (quoting *Baze*, 553 U.S. at 44); here, there is no corresponding medical consensus. Indeed, respondents' expert agreed that he would advise a physician *not* to use midazolam as the sole drug in a painful procedure, J.A. 333, that midazolam is used by itself only in "quick procedures that are not necessarily terribly invasive," and that "even for something like a colonoscopy you would see it used *in combination with a narcotic*." J.A. 307 (emphasis added). Respondents now cite nearly two dozen extra record sources in an effort to change the record, but none establishes a medical consensus that large doses of midazolam will reliably prevent a person from feeling suffocation and pain. That lack of a consensus alone establishes an "objectively intolerable" risk of harm.

Respondents first try to create the appearance of a consensus by claiming that midazolam is used in a range of medical procedures such as setting a femoral IV, dental extraction, or intubation. See Resp. Br. 5–7, 24–25, 42. Respondents are unable, however, to

point to a single source or record evidence establishing a medical consensus that endorses using midazolam as the *sole* agent in seriously painful procedures.[2] Not only would such use be inconsistent with the district court's own finding,[3] but respondents' own sources undermine any such claim. For example, although respondents cite to the landmark study regarding midazolam, they appear to misunderstand the study, by relying upon it for the point that "'midazolam may be used intravenously for the induction of anesthesia' . . . . as an alternative to sodium thiopental . . . ." Resp. Br. 5 (quoting J. G. Reves et al., *Midazolam: Pharmacology and Uses*, 62 Anesthesiology 310, 312, 317–18, 324 (1985)). But the induction of anesthesia refers to quickly sedating a person *before* administering other, potentially more noxious or slower-acting drugs; it is very different than *maintaining* anesthesia. On that point, respondents ignored the key sentence in that same study that follows the one they selectively cite: "[M]idazolam *can*-

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[2] Respondents' contention that intubation is a "'10 out of 10' on the pain scale," Resp. Br 7 & n.2, is unsupported by the source they reference, which does not discuss pain during intubation, and instead references the experiences of individuals who had been on mechanical ventilation for more than 48 hours. *See* Armando J. Rotondi et al., *Patients' Recollections of Stressful Experiences While Receiving Prolonged Mechanical Ventilation in an Intensive Care Unit*, 30 Critical Care Med. 746, 748 (2002). Respondents also cite Dean Evans's testimony that he has heard of midazolam being used to "induce a coma" in "brain-injury patients . . on a continuous infusion," Tr. of Prelim. Inj. Hr'g at 661–62, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17–19, 2014) [hereinafter Tr.], but cannot support what Dean Evans has heard with any citation to scientific literature.

[3] The district court found that midazolam is approved for "*induction* of general anesthesia to be used *before administration of other anesthetic agents*" and is "not an analgesic." J.A. 76 (emphasis added).

not be used alone, however, to maintain adequate anesthesia . . . ." Reves, *supra*, at 312, 317–18 (emphasis added). This source alone illustrates that there is no consensus that midazolam can reliably be used as a sole anesthetic for a painful procedure.

Respondents also assert that the FDA label for midazolam shows that a "'coma' can result" from a large dose. Resp. Br. 5, 42. But the FDA label states only that "[t]he manifestations of midazolam overdosage reported are similar to those observed with other benzodiazepines, including sedation, somnolence, confusion, impaired coordination, diminished reflexes, coma and untoward effects on vital signs." 10th Cir. Supp. Vol. XXII, *Warner* v. *Gross*, No. 14-6244 (10th Cir. Dec. 29, 2014) (Ex. 2 to Report of Larry Sasich, PharmD, Pltfs' Ex. 77) [hereinafter Midazolam Label]. This statement means only that midazolam is associated with some adverse events involving coma; it is not a finding of the FDA that midazolam reliably causes a coma, and any such conclusion is belied by other statements on the label that respondents fail to cite. See, *infra* pp. 13–14.

Respondents try to get around this lack of consensus by arguing that, even if midazolam cannot reliably be used as the sole agent for a painful procedure, it can at least render a person "substantially unaware" of pain, "regardless of the exact depth of consciousness." Resp. Br. 44. Respondents do not explain, however, how the State would measure "substantial unawareness"—indeed, there is no support whatsoever in the record for that term. Nor do they show a medical consensus that midazolam would reliably cause and maintain "substantial unawareness" of suffocation and significant pain.

Respondents also fail to explain how such "substantial unawareness" can be squared with midazolam's

undisputed lack of an analgesic effect. Though respondents claim analgesia is not "relevant to the Eighth Amendment analysis," Resp. Br. 50, the lack of an analgesic effect means that midazolam's ability to prevent pain depends entirely on how reliably midazolam can keep a person unconscious. Once a prisoner is jolted out of unconsciousness, he experiences unblunted, constitutionally unacceptable pain—precisely as Oklahoma's execution of Clayton Lockett illustrated.[4] But unless there are appropriate measures in place to constantly monitor anesthetic depth,[5] any state of awareness more conscious than the "deep, comalike" unconsciousness endorsed in *Baze*—*i.e.*, such as being merely "substantially unaware"—would create an objectively intolerable risk of experiencing substantial pain.

Respondents' argument thus amounts to this: the State wishes to conduct lethal injections using concededly painful, constitutionally intolerable drugs, by first administering a drug that has no analgesic ef-

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[4] Respondents argue that Lockett awoke only because "[e]nough midazolam made it into Lockett's bloodstream to cause temporary induction of unconsciousness, but not enough to maintain an adequate level of unconsciousness." Resp. Br. 14. But the "concentration of midazolam located in Lockett's blood," even after death, "was [still] greater than . . . necessary to render an average person unconscious." J.A. 397. Lockett's waking after 10 minutes had nothing to do with the passage of time, and everything to do with midazolam's inability to reliably maintain unconsciousness through pain. Neither the Lockett execution, the sources respondents cite (*see* Resp. Br. 44 n.18), nor any record evidence supports respondents' assertion that midazolam reliably blunts pain. *See* J.A. 222, 241, 243, 287.

[5] In *Baze*, the concern for careful monitoring and maintenance of anesthetic depth was "obviate[d]" by the undisputed fact that a proper dose of thiopental would reliably ensure a barbiturate coma. 553 U.S. at 59.

fect, is "not anesthesia," but will cause a state of "substantial unawareness" that no text or expert has identified, and that the State has no tools or personnel to measure, monitor, or maintain. This approach poses an objectively intolerable risk of harm, and violates the Eighth Amendment. The decision of the court of appeals should therefore be reversed.

B. The District Court's Findings About Midazolam Were Clearly Erroneous.

The district court committed clear error in finding that a 500 mg dose of midazolam would cause a coma or death. This error independently requires reversal. A lethal-injection protocol using a paralytic and potassium chloride must first reliably place a prisoner into a comalike state for there to be reasonable confidence that the constitutionally intolerable suffocation and pain of those drugs will not stimulate the prisoner into consciousness. Because midazolam is not an analgesic, a prisoner who is jolted into consciousness will feel the full force of the second and third drugs. The district court's finding that midazolam will prevent such a return to consciousness was clearly erroneous.

1. The district court found "that whatever the ceiling effect of midazolam may be with respect to anesthesia, which takes effect at the spinal cord level, there is no ceiling effect with respect to the ability of a 500 milligram dose of midazolam to effectively paralyze the brain." J.A. 78. This explanation of midazolam's ceiling effect is not supported by record evidence, scientific scholarship, or even basic logic. The very meaning of a "ceiling effect" is that, after a certain point, additional doses cease to have any further effect. See Pet. Br. 14–17. If, as all experts testified, midazolam does have a ceiling effect, then Oklahoma's plan to cause a coma by giving a massive dose of

midazolam necessarily falls apart. Here, overwhelming record evidence establishes that midazolam has a ceiling effect that precludes its use as a reliable, sole anesthetic.

First, respondents assert that the ceiling effect only "potential[ly]" or "hypothe[tically]" exists. Resp. Br. 46, 53.[6] But all experts below—including Dean Evans—confirmed that midazolam has a ceiling effect, J.A. 206, 331; Tr. 343; Tr. 664, and the district court found its existence as a fact, J.A. 78.

Second, respondents suggest that the medical literature on midazolam's ceiling effect is "sparse." Resp. Br. 46. But, as the *amicus* brief of sixteen pharmacology professors underscores, a ceiling effect is a fundamental, inherent, and ineluctable property shared by all benzodiazepines. See J.A. 265, 209; Sixteen Professors of Pharmacology *Amicus* Br. 19.[7] Thus, Dean Evans's suggestion that midazolam would have

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[6] Unable to point to any scholarship or record testimony undermining midazolam's ceiling effect, respondents resort to expert testimony from other cases. *See* Resp. Br. 53–54. But the experts in those cases did not testify that midazolam's ceiling effect did not exist, nor did either anesthesiologist testify that he uses midazolam as the sole agent in painful surgical procedures. *See* Transcript of Feb. 11, 2014 Evidentiary Hearing at 233–34, *State* v. *Howell*, No. 1992-cf-22 (Jefferson Cnty., Fla. Cir. Ct. Feb. 13, 2014) (Dr. Dershwitz testifying only that he used midazolam to *induce* anesthesia); Ex. C of Verified Compl. at 112, *Muhammad* v. *Crews*, No. 3:13-cv-1587 (M.D. Fla. Dec. 23, 2013), ECF No. 1–3 (Dr. Heath noting only that he uses midazolam for procedures that are "somewhat uncomfortable").

[7] Respondents cite two of the textbooks upon which the *amicus* brief relies. Resp. Br. 4 (citing Dennis S. Charney et al., *The Pharmacological Basis of Therapeutics* 401 (11th ed. 2006); George Brenner & Craig Stevens, *Pharmacology* 192 (4th ed. 2013)).

a "linear effect" was nothing more than wishful thinking. J.A. 332.[8]

Third, respondents have no defense for Dean Evans's explanation that midazolam's ceiling effect is something affecting only the "spinal column." J.A. 331. Nor could they ever provide such a defense. That explanation lacks any basis in science. See *Gen. Elec. Co.* v. *Joiner*, 522 U.S. 136, 146 (1997) ("[N]othing . . requires a district court to admit opinion evidence that is connected to existing data only by the *ipse dixit* of the expert."). Moreover, and dispositively, this conclusion is undermined by Dean Evans's own testimony that "there are GABA receptors along the entire length of the central nervous system, *not just in the spinal cord*, and that midazolam binds to those GABA receptors . ." Resp. Br. 28 (emphasis added) (citing J.A. 314). Given that midazolam's mechanism of action requires pairing with GABA, there is no way that the ceiling effect—which is purely a function of exhausting the available GABA—could be limited to only one part of the central nervous system. Respondents cannot account for Dean Evans's misunderstanding of these basic facts on the grounds that he was simply using a "shorthand way" of describing GABA. Resp. Br. 47. This is, instead, the classic sort of "internal[] inconsisten[cy]" that constitutes clear error and requires reversal. *Anderson* v. *City of Bessemer City*, 470 U.S. 564, 575 (1985), *quoted in* Resp. Br. 48.

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[8] The study respondents now cite regarding a "linear" increase in midazolam's effect, *see* Resp. Br. 5 n.1, involved administration of midazolam *in conjunction with* the anesthetic drug halothane, and expressly notes that "there may be a ceiling effect of midazolam." Michael A. Melvin et al., *Induction of Anesthesia with Midazolam Decreases Halothane MAC in Humans*, 57 Anesthesiology 238, 240 (1982).

Fourth, respondents try to justify midazolam's constitutionality as the first drug in a lethal-injection protocol by speculating that the ceiling effect may be so high as to be irrelevant here. See Resp. Br. 5–6 n.1, 34. But the study on which respondents rely to show that midazolam's effects increase linearly, and thus, can be used as the sole agent in surgical procedures, actually involved research on the effects of midazolam as an *induction* agent when used *in conjunction with* halothane (an anesthetic). With regard to the ceiling effect, moreover, the researchers noted that "at more than 0.6mg/kg there may be a ceiling effect of midazolam." Melvin, *supra* note 8, at 240. For a 70-kg adult male, that would equate to a ceiling effect after 42 mg of midazolam, which is half the dose administered to Clayton Lockett, and more than ten times less than Oklahoma plans to use in petitioners' executions.

2. Respondents fail to explain why the district court's clear error in crediting Dean Evans's "extrapolation" connecting midazolam's alleged lethality to its ability to reliably cause and maintain a coma does not warrant reversal.

First, there is scant evidence that midazolam can cause death, at any dose. Despite being among the most frequently prescribed medications in the United States, see J.A. 184, petitioners' expert Dr. Lubarsky noted that deaths from midazolam were rare and involved either infirm persons or additional drugs. J.A. 217, 281. Respondents contend that this claim is "undermined by Midazolam's FDA Label, which warns of 'serious and life-threatening cardiorespiratory adverse events' requiring monitoring 'regardless of age or health status.'" Resp. Br. 21; see Resp. Br. 46–47. Respondents ignore the rest of the FDA Label, which is consistent with evidence presented by petitioners:

"[a]dministration of . . . midazolam to elderly and/or high-risk surgical patients has been associated with *rare reports of death* under circumstances compatible with cardiorespiratory depression. *In most of these cases*, the patients also *received other* central nervous system depressants capable of depressing respiration, especially narcotics . ." Midazolam Label 32 (emphasis added); see also *id.* (under "Geriatric Use" warning of "rare reports of death under circumstances compatible with cardiorespiratory depression"). The Label further warns that "[t]he majority of serious adverse effects . . have been reported when midazolam is administered with other medications capable of depressing the central nervous system." *Id.*[9]

Second, even if midazolam can cause death, Dean Evans erred in his calculation of how much midazolam would be needed, mixing up 0.071 mg/kg and 71 mg/kg (a one-thousand-fold difference). See Pet. Br. 36. Respondents rationalize this error as the result of Dean Evans having "inadvertently attached" to his report the wrong data sheet, which itself "contain[ed] an apparent typographical error." Resp. Br. 27 n.16.[10] But on the stand, Dean Evans confirmed that the 71 mg/kg number was correct. J.A. 329. Dean Evans's mistake, no matter the cause, doubly highlights why his testimony was not reliable: if the MSDS could be so in error, that confirms that the MSDS was not a

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[9] Respondents devote significant portions of their brief to impugning Dr. Lubarsky personally, but just as the FDA label directly supports his testimony here about midazolam, so does the medical literature.

[10] Respondents claim that "all parties acknowledge" that preservative-free midazolam "is the midazolam used by Oklahoma." Resp. Br. 27 n.16. Petitioners do not acknowledge, nor do they know, what type of midazolam Oklahoma intends to use in its executions.

reliable source[11]; conversely, if Dean Evans himself knew so little about how much midazolam it takes to kill a person that he could mix up dosages differing by three orders of magnitude, then his testimony is unreliable.

Third, even crediting Dean Evans's testimony and ignoring his mathematical error and unreliable sources, all they show is that some amount of midazolam *might* cause death; they do not prove that it reliably *will* cause death, much less do they establish the extrapolative step that death from a 500 mg dose of midazolam reliably will be preceded by comalike unconsciousness. Indeed, the FDA Label's warnings about the risks of overdose refer to problems with cardio-respiratory depression, not cessation of brain activity. Midazolam Label 32–34. That contrasts starkly with the corresponding warning on pentobarbital's label that, "[i]n extreme overdose, all electrical activity in the brain may cease." Akorn, *Label: Nembutal Sodium Solution*, http://akorn.com/documents/catalog/package_inserts/76478-501-20.pdf (last visited Apr. 20, 2015).[12]

Respondents cannot defend Dean Evans's extrapolation as consistent with basic principles of scientific

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[11] Despite respondents' contentions, it is irrelevant if drugs.com and the MSDS happen to contain correct information. See Resp. Br. 47 n.19. The relevant inquiry is whether those sources "enjoy[] 'general acceptance' within a 'relevant scientific community,'" *Kumho Tire Co.* v. *Carmichael*, 526 U.S. 137, 149–50 (quoting *Daubert* v. *Merrell Dow Pharm.*, 509 U.S. 579, 592–94 (1993)), and they do not.

[12] The defining characteristic of a "coma" is that a person "cannot be aroused, even by powerful stimulation." *Dorland's Illustrated Medical Dictionary* 358 (28th ed. 1994) (definition of "coma"); J.A. 209 ("electrical activity in the brain has stopped"); J.A. 210.

inquiry. Rather, given overwhelming scientific evidence of midazolam's mechanism of action and effects, Dean Evans's opinion was and is indefensible, amounting only to guesswork. Such is not the stuff of reliable expert testimony, nor can it plausibly establish with any degree of reliability midazolam's efficacy for use in a three-drug protocol. See *Anderson*, 470 U.S. at 574.

3. Finally, petitioners did not waive their challenge to the district court's findings of fact or to its reliance on Dean Evans's testimony. Petitioners moved in limine to challenge his expert report, J.A. 35–36, which the district court treated as a "challeng[e to] both Dr. Evans'[s] qualifications and his methodology," J.A. 72, 133. Moreover, both the district court and court of appeals independently assessed Dean Evans's testimony's relevance and reliability. See J.A. 132, 134. Those issues are fully preserved.

Furthermore, even when a failure to raise a *Daubert* challenge does "make it impossible for petitioners to argue that [an expert's] testimony was not 'admissible evidence' under the Rules[,] . it does not make it impossible for them to argue that the evidence [itself] failed" to satisfy the relevant legal standard. *Comcast Corp.*, 133 S. Ct. at 1431 n.4. Petitioners' challenge to findings of fact based on that testimony thus have not been "forfeited." *Id.* The "obvious and exceptional" error of Dean Evans's testimony merits reversal. *Id.* at 1433 n.5.[13]

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[13] If the Court has concerns regarding the factual record, the Court could remand for the district court to conduct further factual proceedings based on this Court's clarification of the proper standard for evaluating what constitutes a constitutionally tolerable level of risk in a lethal-injection protocol.

III. PETITIONERS ARE ENTITLED TO A STAY OF EXECUTION FOR HAVING SHOWN A SIGNIFICANT POSSIBILITY OF SUCCESS ON THE MERITS.

1. The Tenth Circuit misconstrued *Baze* to impose an extra requirement for obtaining a stay that has proved all but insurmountable in this and other cases.

Respondents contend that, because the Tenth Circuit cited *Hill* in discussing the standard for a preliminary injunction, it should not be presumed to have "*sub silentio* substituted that standard" for something more demanding. Resp. Br. 58. Petitioners presume nothing on this point—the court of appeals expressly stated that "the demonstration of a risk of severe pain" was the "first requirement for a stay of execution." J.A. 130; see *Wackerly* v. *Jones*, 398 F. App'x 360, 362 (10th Cir. 2010) (same). Whether the Tenth Circuit viewed *Baze* as displacing the stay standard in *Hill* or as interpreting the meaning of the phrase a "significant probability of success on the merits," the result is the same: The Tenth Circuit interpreted *Baze* to require petitioners to establish that the State's protocol creates a "demonstrated risk" of severe pain, *Baze*, 553 U.S. at 61. This Court should clarify whether it intended to create such a high hurdle for injunctive relief.

2. After assuming that *Baze* created a more demanding stay standard, respondents argue that *Baze*'s express limitation to challenges brought "'on grounds such as those asserted there'" means that "*Baze* applies any time a stay of execution is requested." Resp. Br. 59–60. But it does not follow that *Baze* applies to challenges to *all* methods of execution. Resp. Br. 57–58; J.A. 131. Instead, any uniquely high stay standard emanating from *Baze* should apply on-

ly to those capital cases seeking to improve upon existing safeguards against the "maladministration of a concededly humane [execution] protocol." 553 U.S. at 41, 60–61. Respondents contend that this distinction fails because "the *Baze* petitioners ['hardly'] conceded that the 'State's method, if administered according to plan, would be constitutional.'" Resp. Br. 60. But the *Baze* plurality clearly stated that petitioners "concede[d] that 'if performed properly,' an execution carried out under Kentucky's procedures would be 'humane and constitutional.'" 553 U.S. at 49 (quoting Brief for Petitioners 31).

Where a state's intended method has been found to be constitutional and the only question is whether the state must adopt new safeguards to reduce the risks of harm, a higher stay hurdle is logical. Conversely, a higher stay hurdle does not make sense where, as here, petitioners challenge a drug that is *incapable* of serving as a reliable anesthetic, irrespective of any safeguards. A claim that a state's execution protocol, even if carried out as written, will not be constitutional, warrants a stay once there is "a significant possibility of success on the merits." *Hill*, 547 U.S. at 584 (citing *Barefoot*, 463 U.S. at 895).

IV. THE EIGHTH AMENDMENT DOES NOT REQUIRE PETITIONERS TO REMEDY A STATE'S UNCONSTITUTIONAL ACT.

The Eighth Amendment prohibits certain punishments regardless of whether alternatives are available. Respondents argue, however, that even a cruelly inhumane execution can constitutionally be carried out if petitioners fail to plead and prove an alternative, available method. Otherwise, respondents contend, petitioners are "challeng[ing] the death penalty itself" and leaving Oklahoma "without any alternative to effectuate its laws." Resp. Br. 63. The premises

of this argument are false, and respondents' conclusion should be rejected.

First, petitioners are not challenging lethal injection per se, but just this specific combination of drugs. See J.A. 66–67; Am. Compl. at ¶ 24, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Oct. 31, 2014), ECF No. 75. Petitioners did propose sodium thiopental and pentobarbital as alternatives, *id.* at ¶ 31, and these drugs are still approved in Oklahoma's recently "revamped" protocol. That those drugs may not presently be commercially available to Oklahoma does not mean that petitioners are challenging their death sentences. See *Hill*, 547 U.S. at 582 (permitting claim of cruel and unusual punishment to proceed even though prisoner did not specify an alternative method of execution).

Second, respondents argue that, without a prisoner-selected replacement for midazolam, Oklahoma would be left "without any alternative to effectuate its laws." Resp. Br. 63. But Oklahoma has never argued that it has *no* alternative for carrying out lethal injection available to it, nor did the district court find any such fact. Rather, all the district court found was that two barbiturates, sodium thiopental and pentobarbital were currently "not available to the DOC" for lethal injection. J.A. 127; see also Tr. 296 ("The [State's] vendor . . didn't want to sell [Oklahoma] pentobarbital any longer."). The district court did not have an opportunity to consider that Texas, Georgia, and Missouri have carried out eleven executions using pentobarbital since January.[14] Nor did Oklahoma explain why other states can access pentobarbital

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[14] *See Execution List 2015*, Death Penalty Information Center, http://www.deathpenaltyinfo.org/execution-list-2015 (last visited Apr. 21, 2015).

while Oklahoma's "exhaustive search" has failed to locate the same. Resp. Br. 11. In fact, the letter respondents cite as proof of pentobarbital's unavailability to Oklahoma (which respondents assert was sent by "Oklahoma's supplier of compounded pentobarbital" to the "ODOC," Resp. Br. 11), was actually sent from a *Texas* pharmacy to the *Texas* Department of Corrections in 2013. See Pls.' Opp. to Defs.' Mot. for Protective Order & Br. in Supp. at 16 n.7, *Warner* v. *Gross*, No. 5:14-cv-665 (W.D. Okla. Oct. 21, 2014), ECF No. 68 (citing Notice of Exhibit, *Schad* v. *Brewer*, No. 13-cv-2001-ROS (D. Ariz. Oct. 4, 2013), ECF Nos. 21 & 21-1 (where the letter was publicly filed by the Arizona Department of Corrections)). The letter also is inadequate because Oklahoma has approved four different methods of lethal injection, J.A. 117–18, and because its governor just signed a measure automatically endorsing lethal injection, nitrogen hypoxia, electrocution, or the firing squad, in that order, if any method is ruled unconstitutional *or* becomes unavailable. See 2015 Okla. Sess. Laws Ch. 75 (H.B. 1879).

Third, respondents argue that the lack of alternatives, when caused by "the decisions of third parties," makes it "logical and necessary" for the State to use whatever methods it has at its disposal. Resp. Br. 63–64. Although "capital punishment is constitutional," *Baze*, 553 U.S. at 47, that precept does not require this Court to condone *any* method of execution—much less one as painful as the one under review here—simply because Oklahoma reports that it has run out of methods other than the one under review. The Bill of Rights' guarantees are not diminished even by true emergencies, *Ex parte Milligan*, 71 U.S. 2, 120 (1866) (holding that wartime closure of courts did not permit abrogation of Sixth Amendment

rights), much less by Oklahoma-specific supply shortages. If the particular three-drug protocol at issue here is ruled unconstitutional, then Oklahoma will find another protocol, as it has in the past. See Resp. Br. 9–14.

Fourth, respondents offer no justification for why, if the State lacks other options, prisoners must articulate the remedy for the State's constitutional missteps. Such a requirement is unprecedented in Eighth Amendment jurisprudence, see, *e.g.*, *Trop* v. *Dulles*, 356 U.S. 86, 103 (1958) (plurality opinion); *Weems* v. *United States*, 217 U.S. 349, 382 (1910); a proposition that respondents do not even attempt to refute. It is also illogical, in that petitioners cannot know the availability to Oklahoma of particular drugs because Oklahoma keeps the identity of its pharmaceutical sources confidential. Any such rule, moreover, would restrict rather than respect state sovereignty, because a prisoner-proposed alternative might conflict with the State's legislatively authorized set of backup execution methods, see *supra* p. 19, which would lead to federalism concerns not present if the State were free to construct its own constitutional means of carrying out death sentences. See *Rizzo* v. *Goode*, 423 U.S. 362, 379–80 (1976).

Finally, respondents contend that *Hill* v. *McDonough* merely clarified pleading standards for § 1983 claims raising Eighth Amendment issues, and did not speak to the elements of an Eighth Amendment claim. Resp. Br. 58. That argument is not tenable. The Court "unanimously rejected a proposal that § 1983 suits challenging a method of execution must identify an acceptable alternative." *Jones* v. *Bock*, 549 U.S. 199, 213 (2007) (construing *Hill*, 547 U.S. at 581–82). The core issue in *Hill* was whether an Eighth Amendment plaintiff had to plead an alterna-

tive; in holding that he need not, the Court made no distinction between what must be pleaded and what must be proven, nor between the elements of a § 1983 claim and the underlying Eighth Amendment right. Nor would such a distinction make sense, given that any similar Eighth Amendment challenge would arise virtually only in the context of a § 1983 claim. Moreover, even if *Baze* and *Hill* had "addressed two entirely separate questions," Resp. Br. 65–66, construing *Baze* as respondents suggest would all but vitiate *Hill*'s holding, which this Court does not ordinarily do *sub silentio*. See *Shalala* v. *Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 18 (2000).

CONCLUSION

For the foregoing reasons and those stated in our opening brief, the judgment of the court of appeals should be reversed.

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RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Tenth Circuit

BRIEF OF THE ADVOCATES FOR HUMAN RIGHTS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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QUESTIONS PRESENTED

1. Is it constitutionally permissible for a state to carry out an execution using a three-drug protocol where:

   (a) there is a well-established scientific consensus that the first drug has no pain relieving properties and cannot reliably produce deep, comalike unconsciousness, and

   (b) it is undisputed that there is a substantial, constitutionally unacceptable risk of pain and suffering from the administration of the second and third drugs when a prisoner is conscious?

2. Does the *Baze*-plurality stay standard apply when states are not using a protocol substantially similar to the one that this Court considered in *Baze*?

3. Must a prisoner establish the availability of an alternative drug formula even if the state's lethal-injection protocol, as properly administered, will violate the Eighth Amendment?

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED.....i

TABLE OF CONTENTS.....ii

TABLE OF AUTHORITIES.....iii

INTEREST OF THE AMICUS.....1

SUMMARY OF ARGUMENT.....1

ARGUMENT.....3

I. Oklahoma's lethal injection protocol violates international law.....3

A. Oklahoma's proposed lethal injection protocol fails to minimize the risk of suffering to Petitioners, in violation of the ICCPR and the Torture Convention.....4

B. Oklahoma's proposed lethal injection protocol constitutes non-consensual human experimentation prohibited under the ICCPR.....10

II. International law provides persuasive authority for interpreting the constitutional issues before this Court.....17

CONCLUSION.....19

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Atkins v. Virginia, 536 U.S. 304 (2002).....18

Baze v. Rees, 553 U.S. 35 (2008).....2

Graham v. Florida, 560 U.S. 48 (2010).....17, 18

Grutter v. Bollinger, 539 U.S. 306 (2003).....18

Lawrence v. Texas, 539 U.S. 558 (2003).....18

Roper v. Simmons, 543 U.S. 551 (2005).....17

Thompson v. Oklahoma, 487 U.S. 815 (1988).....18

Trop v. Dulles, 356 U.S. 86 (1958).....2, 17

CONSTITUTION

U.S. Const. amend. VIII.....2, 17

FOREIGN CASES

Ng v. Canada, Communication No. 469/1991, U.N. Doc. CCPR/C/49/D/469/1991 (1994).....6

Viana Acosta v. Uru., Comm. 110/1981, U.N. Doc. A/39/40, at 169 (HRC 1984).....12

TREATIES

Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, Dec. 10, 1984, 108 Stat. 382, 1465 U.N.T.S. 85.....3, 6, 7, 9

International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16), U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976.....3, 9, 11, 16

OTHER AUTHORITIES

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Ahcene Boulesbaa, The U.N. Convention on Torture and the Prospects for Punishment (1999).....7, 19

Committee against Torture, "Concluding observations on the combined third to fifth periodic reports of the United States of America," UN Doc. CAT/C/USA/CO/3-5, December 19, 2014.....7, 9

Development & Approval Process (Drugs), U.S. Food and Drug Administration, *available at* http://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm (last visited March 10, 2015)....13, 14

Jeffrey L. Dunoff et al., International Law Norms, Actors, Process: A Problem-Oriented Approach (3d Ed.) (2010).....19

How Drugs are Developed and Approved, U.S. Food and Drug Administration, *available at* http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/default.htm (last visited March 10, 2015).....13

Human Rights Committee, "Concluding observations on the fourth periodic report of the United States of America," UN Doc. CCPR/C/USA/CO/4, April 23, 2014.....10, 16

Human Rights Committee, General Comment 20, (Forty-fourth session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 (1994), *available at* http://www1.umn.edu/humanrts/gencomm/hrcom20.htm (last visited March 10, 2015).....5, 15

Matthew Lippman, *The Development and Drafting of the United Nations Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment*, 17 B.C. Int'l & Comp. L. Rev. 275 (1994).....11

Zain Mithani, *Informed Consent for Off-Label Use of Prescription Medications*, Op-ed., 14 Am. Med. Ass'n J. Ethics 576 (2012).....14

Manfred Nowak, U.N. Covenant on Civil and Political Rights, CCPR Commentary (2d Rev. Ed.) (2005).....5, 6, 11, 12

"Off-Label" and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices Information Sheet, U.S. Food and Drug Administration, *available at* http://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm (last visited March 13, 2015).....14

Safeguards Guaranteeing Protection of the Rights of Those Facing the Death Penalty, E.S.C. Res. 1984/50, annex, 1984 U.N. ESCOR Supp. (No. 1), U.N. Doc. E/1984/84 (1984).....5, 7, 9

Status of Ratification Interactive Dashboard, Office of the High Commissioner for Human Rights, United Nations, *available at* http://indicators.ohchr.org/ (last visited March 13, 2015).....4

U.N. GAOR, 38th Sess., 93d plan. Mtg., at 1667, U.N. Doc. A/39/PV.93 (1984).....20

Understanding Investigational Drugs and Off Label Use of Approved Drugs, U.S. Food and Drug Administration, *available at* http://www.fda.gov/forpatients/other/offlabel/default.htm (last visited March 10, 2015).....14

United Nations Audiovisual Library of International Law, *Introductory Note*, Hans Danelius, Codification Division, Office of Legal Affairs, United Nations, *available at* http://legal.un.org/avl/ha/catcidtp/catcidtp.html (last visited March 10, 2015).....6, 7

INTEREST OF THE AMICUS[1]

The Advocates for Human Rights (The Advocates), established in 1983, is a volunteer-based nongovernmental organization committed to the impartial promotion and protection of international human rights standards and the rule of law. The Advocates has engaged in issue-specific advocacy opposing capital punishment for many years, and in 1991 it adopted a formal commitment to oppose the death penalty worldwide, organizing a Death Penalty Project to provide pro bono assistance on post-conviction appeals, as well as education and advocacy to end capital punishment. The Advocates serves on the Steering Committee of the World Coalition Against the Death Penalty. The Advocates is opposed to the death penalty and has a strong interest in ensuring that as long as capital punishment is practiced in the United States, execution methods conform to international human rights standards.

SUMMARY OF ARGUMENT

Oklahoma's experimental use of the drug midazolam in its lethal injection protocol creates a substantial risk that Petitioners will be subjected to unnecessary suffering, in violation of the Eighth Amendment to the U.S. Constitution as interpreted in light of international law as a reflection of our

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[1] Amicus states that no party or their counsel has authored this Brief in whole or in part nor has any person or entity other than amicus and its counsel made monetary contributions to its preparation. All parties have consented to the filing of this Brief, and letters of consent have been lodged with the Clerk of the Court.

"evolving standards of decency." U.S. Const. amend. VIII; *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion). Oklahoma's execution methods violate international human rights law in two respects. First, international human rights law requires that, when governments conduct executions, those executions are carried out in a manner that results in the minimum possible suffering. Second, international human rights law prohibits medical or scientific experimentation on prisoners, and Oklahoma's novel protocol amounts to such experimentation.

This Court's decision in *Baze v. Rees* relied on an assurance that a prisoner would be properly anesthetized before the administration of the two subsequent and indisputably pain- inducing drugs. *See Baze v. Rees*, 553 U.S. 35, 53 (2008). Oklahoma, under its new protocol, cannot provide that assurance. As Petitioners demonstrate, the protocol as written is experimental. It employs midazolam as an anesthetic agent, yet that drug is not approved for use nor is it used as a stand-alone anesthetic in stimulating medical procedures. Nor has the U.S. Food and Drug Administration (FDA) approved its use on humans for purposes of a stand-alone anesthetic in surgical procedures. Moreover, midazolam has not been proven to reliably render individuals unconscious. States' unscientific trial-and-error process of assessing the effectiveness of midazolam as an anesthetic in lethal injection protocols is experimental, and its administration is known to result in a substantial risk of unnecessary suffering.

This Court has consistently recognized international law and standards as persuasive

sources of authority to determine what conduct constitutes "cruel and unusual punishment" prohibited by the Eighth Amendment. The Advocates for Human Rights respectfully urges the Court to consider international human rights standards in assessing the constitutionality of Oklahoma's proposed lethal injection protocol. Oklahoma's lethal injection protocol is experimental and poses a substantial risk of unnecessary suffering. As such, the protocol violates the Eighth Amendment's prohibition against "cruel and unusual punishment" as reflected in the international prohibitions against non-consensual human experimentation and execution methods that cause unnecessary suffering.

ARGUMENT

I. Oklahoma's lethal injection protocol violates international law.

By using midazolam as the anesthetic in its lethal injection protocol, Oklahoma is subjecting Petitioners to medical or scientific experimentation in a manner that fails to minimize their risk of suffering, in violation of the United States' obligations under international human rights law. By ratifying both the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, Dec. 10, 1984, 108 Stat. 382, 1465 U.N.T.S. 85 (ratified by the United States on Oct. 21, 1994) [hereinafter "Torture Convention"] and the International Covenant on Civil and Political Rights, G.A. res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16), U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976 (ratified by the United States

on June 8, 1992) [hereinafter "ICCPR"], the United States joined most countries around the world[2] in recognizing that torture and cruel, inhuman, and degrading treatment or punishment, including execution methods that cause avoidable suffering, as well as non-consensual medical or scientific experimentation on human beings, violate fundamental human rights. International law, as reflected in these two treaties, provides strong persuasive authority for interpreting the constitutional issues before this Court.

A. Oklahoma's proposed lethal injection protocol fails to minimize the risk of suffering to Petitioners, in violation of the ICCPR and the Torture Convention.

Oklahoma's proposed lethal injection protocol violates the United States' obligations under the Torture Convention and the ICCPR, treaties signed and ratified by the United States, because midazolam will not induce the comalike state of unconsciousness necessary to minimize the suffering that Petitioners will experience during their executions.

International human rights law requires that executions be carried out in a manner that inflicts the minimum possible suffering. In 1984, for example,

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[2] As of March 13, 2015, one hundred fifty-seven states were parties to the Torture Convention, and one hundred sixty-eight states were parties to the ICCPR. Status of Ratification Interactive Dashboard, Office of the High Commissioner for Human Rights, United Nations, *available at* http://indicators.ohchr.org/ (last visited March 13, 2015).

the United Nations Economic and Social Council adopted a resolution establishing safeguards guaranteeing protection of the rights of individuals facing the death penalty. Safeguards Guaranteeing Protection of the Rights of Those Facing the Death Penalty, E.S.C. Res. 1984/50, annex, 1984 U.N. ESCOR Supp. (No. 1), U.N. Doc. E/1984/84 (1984) [hereinafter "Safeguards"]. The Safeguards recognize that "[w]here capital punishment occurs, it shall be carried out so as to inflict the minimum possible suffering." *Id.*, para. 9. The ICCPR and the Torture Convention—treaties the United States ratified in 1992 and 1994 respectively—reaffirm this standard under international human rights law.

Article 7 of the ICCPR prohibits both torture and cruel, inhuman, or degrading treatment or punishment, including executions resulting in unnecessary suffering. In interpreting Article 7, the Human Rights Committee—the body tasked with monitoring treaty compliance by governments that have ratified the ICCPR—has stated that the death penalty, if practiced, must "be carried out in such a way as to cause the least possible physical and mental suffering."[3] Human Rights Committee, General Comment 20, Article 7 (Forty-fourth session, 1992), Compilation of General Comments and

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[3] General Comment 20 thus aligns ICCPR's prohibitions on torture and non-consensual scientific and medical experimentation on human beings with the human rights standards espoused by the Safeguards. *See* Safeguards, para. 9. The Human Rights Committee's General Comments "are considered to be the most authoritative interpretation of the Covenant's provisions." Manfred Nowak, U.N. Covenant on Civil and Political Rights, CCPR Commentary (2d Rev. Ed.) (2005), at XXII [hereinafter "Nowak"].

General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 (1994), *available at* http://www1.umn.edu/humanrts/gencomm/hrcom20.htm (last visited March 10, 2015). [hereinafter "General Comment 20"]. Any execution protocol that causes unnecessary suffering therefore violates Article 7 of the ICCPR. For example, the Human Rights Committee has established that execution by stoning or by gas asphyxiation constitutes cruel and inhuman treatment.[4]

Like the ICCPR, the Torture Convention prohibits execution methods that inflict more than the minimum possible suffering. The Torture Convention "promote[s] universal respect for, and observance of, human rights and fundamental freedoms" by memorializing the principle that "no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[5] Torture

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[4] Nowak at 164, 171 (citing *Ng v. Canada*, Communication No. 469/1991, U.N. Doc. CCPR/C/49/D/469/1991 (1994) § 16.3-.4).

[5] The Torture Convention entered into force in accordance with its terms on June 26, 1987. *See* Torture Convention. The Torture Convention was drafted to build upon and reinforce the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, a prior United Nations effort to develop international human rights standards defining and prohibiting torture. United Nations Audiovisual Library of International Law, *Introductory Note*, Hans Danelius, Codification Division, Office of Legal Affairs, United Nations, *available at* http://legal.un.org/avl/ha/catcidtp/catcidtp.html (last visited March 10, 2015). In particular, the Torture Convention strengthened and refined the Declaration's definition of torture and established the Committee against Torture to monitor and

Convention, pmbl. The United States played a key role in the treaty's negotiations and pressed for the inclusion of the latter provision, prohibiting cruel, inhuman, and degrading treatment or punishment, in addition to the prohibition on torture. Ahcene Boulesbaa, The U.N. Convention on Torture and the Prospects for Punishment (1999), at 6 [hereinafter "Boulesbaa"]. Parties to the Torture Convention also must take steps "to prevent acts of cruel, inhuman or degrading treatment or punishment" by public officials, even if those acts do not rise to the level of torture. Torture Convention, art. 16(1).

The Committee against Torture, the body of experts responsible for monitoring implementation of the Torture Convention, interprets these obligations to mean that execution methods must "prevent pain and prolonged suffering," and must "inflict the minimum possible suffering," consistent with the Safeguards. Committee against Torture, "Concluding observations on the combined third to fifth periodic reports of the United States of America," UN Doc. CAT/C/USA/CO/3-5, December 19, 2014, para. 25 [hereinafter "CAT Concluding Observations"]; Safeguards, para. 9.[6]

Oklahoma's protocol violates the "minimum possible suffering" standard. The protocol calls for

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assess the implementation of the Torture Convention in the countries that became parties to it. *Id.*

[6] The Safeguards cited approvingly by the Committee against Torture were approved by Economic and Social Council resolution 1984/50 of 25 May 1984, approximately four years before the United States became a signatory to the Torture Convention, and approximately ten years before the United States ratified the Torture Convention.

three drugs to be administered sequentially. Oklahoma first injects midazolam in an effort to anesthetize the prisoner to the pain and suffering that the second and third drugs of the protocol will undeniably cause. The second drug in the protocol paralyzes—and eventually suffocates—the prisoner. Finally, Oklahoma injects the prisoner with potassium chloride, inducing cardiac arrest. Pet'rs' Br. at 2.

Medical professionals do not use midazolam as a stand-alone anesthetic for painful surgical procedures. Nor has the FDA approved midazolam for use as a stand-alone anesthetic; clinical trials show that persons rendered unconscious by midazolam can be "jolted into consciousness" by the infliction of pain. *Id.* at 13. For these reasons, as Petitioners demonstrate, midazolam is inherently incapable of reliably inducing and maintaining the deep, comalike unconsciousness caused by barbiturates such as sodium thiopental and pentobarbital, which shield the prisoner from the painful effects of the second and third drugs in the protocol. *Id.* at 2-3.

The recent botched executions in Arizona, Ohio, and Oklahoma have borne out midazolam's ineffectiveness as an anesthetic in lethal injection protocols. *Id.* at 20-21. During these executions, all three condemned prisoners struggled and, in at least one case, appeared to regain consciousness after the administration of midazolam. All three condemned prisoners apparently experienced excruciating pain. *See id.* These results are fundamentally incompatible with the United States' obligations under the Torture Convention and the ICCPR to minimize the risk of suffering.

In its recent periodic review of the United States' compliance with the Torture Convention, the Committee against Torture expressed concern regarding these recent botched executions because reports suggested the prisoners had experienced preventable suffering. The Committee cautioned the U.S. government that execution methods must be "carried out so as to inflict the minimum possible suffering" and "expresse[d] concern at reported cases of excruciating pain and prolonged suffering that procedural irregularities have caused condemned prisoners in the course of their execution." CAT Concluding Observations, para. 25. The Committee was "specially troubled" by the recent botched executions in Arizona, Oklahoma, and Ohio—all involving lethal injection protocols that used midazolam—and urged the United States to "review its execution methods in order to prevent pain and prolonged suffering," in line with internationally recognized safeguards guaranteeing minimum possible suffering. *Id.*; Safeguards, para. 9.[7]

As a party to the Torture Convention and the ICCPR, the United States has agreed to take effective legislative, administrative, judicial, or other measures to prevent acts of torture and cruel, inhuman, or degrading punishment within its jurisdiction. Torture Convention, arts. 2, 16(1); ICCPR, arts. 2(1), 7. Oklahoma must therefore refrain from using execution protocols that inflict

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[7] The Committee invoked paragraph nine of the Safeguards Guaranteeing Protection of the Rights of Those Facing the Death Penalty, which requires that "where capital punishment occurs, it shall be carried out so as to inflict the minimum possible suffering." Safeguards, para. 9.

preventable pain upon the condemned. Because Oklahoma's lethal injection protocol is likely to inflict more than the minimum possible suffering upon Petitioners, Oklahoma's protocol violates the United States' obligations under the ICCPR and the Torture Convention.

B. Oklahoma's proposed lethal injection protocol constitutes non-consensual human experimentation prohibited under the ICCPR.

By using midazolam as a stand-alone anesthetic in its lethal injection protocol—a use never employed in the medical community and a purpose for which the FDA has not approved the drug—Oklahoma violates the ICCPR's prohibition against non-consensual medical or scientific human experimentation. Respondent has cited no scientific support for the use of midazolam as a safe, effective anesthetic in procedures resulting in pain akin to that imposed during the lethal injection process. Accordingly, its use is experimental, and because such use would result in a risk of pain and suffering, that use violates the ICCPR's prohibition on non-consensual medical and scientific experimentation. Indeed, the Human Rights Committee, in response to concerns about the safety and efficacy of drugs used in lethal injections across the country, recently urged the United States to "ensure that lethal drugs used for executions originate from legal, regulated sources, and are approved by the United States Food and Drug Administration." Human Rights Committee, "Concluding observations on the fourth periodic report of the United States of America," UN Doc.

CCPR/C/USA/CO/4, April 23, 2014, para. 8 [hereinafter "ICCPR Concluding Observations"].

The ICCPR's prohibition against torture and cruel, inhuman, or degrading punishment includes a provision expressly prohibiting experimentation on non-consenting human beings: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, *no one shall be subjected without his free consent to medical or scientific experimentation.*" ICCPR, art. 7 (emphasis added).

The ICCPR does not otherwise define torture or cruel, inhuman, or degrading treatment or punishment; human experimentation is the single example the treaty provides.[8] Some government representatives involved in drafting the prohibition suggested that "improper medical or scientific experimentation was implicitly prohibited in the first clause" of Article 7, but "[i]t was finally agreed that the matter was so important to require a specific provision, even at the risk of repetition." Marc J. Bossuyt, Guide to the "*Travaux Preparatoires*" of the

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[8] The governments that drafted Article 7's specific prohibition on non-consensual human experimentation introduced the provision in response to the atrocities committed against prisoners in Nazi concentration camps. Nowak, at 188. The Nazis conducted "a series of unprecedented, gruesome medical experiments on concentration camp inmates," including, for example, exposing inmates to malaria, mustard gas, jaundice, and spotted fever, and removing sections of bones, muscles, and nerves and transplanting them to other inmates. Matthew Lippman, *The Development and Drafting of the United Nations Convention Against Torture and Other Cruel Inhuman or Degrading Treatment or Punishment*, 17 B.C. INT'L & COMP. L. REV. 275, 287 (1994).

International Covenant on Civil and Political Rights (1987), at 151-152 [hereinafter "Bossuyt"]. The United States joined other UN member-states in supporting the addition of this provision.[9]

The prohibition extends to "experiments that by their very nature are to be deemed torture or cruel, inhuman or degrading treatment." Manfred Nowak, U.N. Covenant on Civil and Political Rights, CCPR Commentary (2d Rev. Ed.) (2005), at 191 (emphasis removed). In that context, the Human Rights Committee concluded that forced injections of a prisoner are inhuman under the meaning of Article 7. *Id.* at 192 (citing *Viana Acosta v. Uru.*, Comm. 110/1981, U.N. Doc. A/39/40, at 169 (HRC 1984), §§ 2.7, 14–15).

Scientific evidence does not support midazolam's effectiveness as a stand-alone anesthetic for painful procedures. Oklahoma does not identify any substantial body of scientific research supporting the use of midazolam for this purpose or show that a medical consensus supports such use. Moreover, the FDA has not approved midazolam for use as a stand-alone anesthetic in painful procedures; nor does other scientific research or medical consensus support such use. Accordingly, its use in this case is experimental and will result in a risk of suffering in violation of Article 7 of the ICCPR.

By using midazolam as a stand-alone anesthetic in its lethal injection protocol, Oklahoma embarks on an intolerable human experiment in

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[9] In expressing its support, the United States proposed exceptions for "[e]mergency operations undertaken to save the life of [a] patient, where the patient is unable to give his consent" and for compulsory vaccinations. Bossuyt, at 151-152.

violation of international human rights standards. The FDA's oversight and approval process provides guidance as to what makes a particular drug use experimental. The FDA requires a rigorous and evidence-based review of a drug's safety and efficacy before the drug may obtain FDA approval. How Drugs are Developed and Approved, U.S. Food and Drug Administration, *available at* http://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/ default.htm (last visited March 10, 2015). [hereinafter "FDA: How Drugs are Developed and Approved"]. Even before seeking FDA approval, a drug company must conduct its own scientific testing to demonstrate the drug's safety and efficacy to the FDA. Development & Approval Process (Drugs), U.S. Food and Drug Administration, *available at* http://www.fda.gov/Drugs/DevelopmentApprovalProcess/default.htm (last visited March 10, 2015) [hereinafter "FDA: Development & Approval"]. Before any human testing takes place, a drug company first conducts laboratory and animal tests to assess the drug's safety and efficacy. *Id.* FDA doctors, scientists, pharmacologists, and statisticians then subject these test results to exhaustive review before the FDA approves the drug for its intended use. FDA: How Drugs are Developed and Approved. The FDA's comprehensive, methodical drug screening process "not only prevents quackery, but also provides doctors and patients the information they need to use medicines wisely." FDA: Development & Approval. The unapproved use of an approved drug poses serious risks because "the makers of the drugs have not put them through the formal, lengthy, and often

costly studies required by FDA to officially approve the drug for new uses." Understanding Investigational Drugs and Off Label Use of Approved Drugs, U.S. Food and Drug Administration, *available at* http://www.fda.gov/forpatients/other/offlabel /default.htm (last visited March 10, 2015).[10] Such "off-label" uses must be subject to a rigorous informed consent procedure. *See, e.g.*, Zain Mithani, *Informed Consent for Off-Label Use of Prescription Medications*, Op-ed., 14 Am. Med. Ass'n J. Ethics 576 (2012). As noted below, however, international human rights law recognizes that no such consent can be forthcoming from a prisoner.

Oklahoma's use of midazolam as a stand-alone anesthetic is quintessentially the "quackery" that the FDA approval process intends to prevent, further demonstrating that the protocol constitutes human experimentation. *See* FDA: Development & Approval. Oklahoma alleges that ostensibly successful executions of condemned prisoners in Florida, as well as of one prisoner in Oklahoma, using Oklahoma's favored lethal injection protocol support the conclusion that the protocol is not experimental. Br. in Opp'n. to Pet. Writ. Cert., January 14, 2015, at 4; Resp. to Pet'rs' Appl. for Stays of Execution, January

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[10] While there are some instances in which off-label drugs are used, off-label use is sanctioned by the FDA only when it is done for a valid medical purpose and is based on "firm scientific rationale and on sound medical evidence." "Off-Label" and Investigational Use Of Marketed Drugs, Biologics, and Medical Devices Information Sheet, U.S. FOOD AND DRUG ADMINISTRATION, *available at* http://www.fda.gov/RegulatoryInformation/Guidances/ucm126486.htm (last visited March 13, 2015). Respondent has not met this standard.

14, 2015 at 3; Resp'ts' Appl. for Stays of Execution of Sentences of Death, filed January 26, 2015, at 3. Yet the administration of a paralytic drug in these protocols effectively masks to observers any suffering a prisoner might be enduring. It is therefore inappropriate to conclude, as any sort of quasi-experimental finding, that the prisoners did not suffer during their executions. Further, these executions that Oklahoma offers as evidence were not designed to test the effectiveness of midazolam as an anesthetic for lethal injections. These executions present nothing more than a series of anecdotes; they do not serve as scientific data that would render Oklahoma's planned executions of Petitioners non-experimental.

The Human Rights Committee has recognized that any medical or scientific experimentation performed on persons "under any form of detention or imprisonment" is inherently coercive and hence non-consensual. General Comment 20, para 7. The Committee further acknowledged that incarcerated "persons should not be subjected to any medical or scientific experimentation that may be detrimental to their health." *Id. A fortiori*, such individuals should not be subjected to medical or scientific experimentation that will inevitably result in death. Article 7 thereby directs that Petitioners cannot be subjected to medical or scientific experimentation because their status as prisoners vitiates their ability to grant valid consent to such experimentation.

The Human Rights Committee recently encouraged the United States to take measures to monitor lethal injection protocols and to ensure that the protocols use only drugs that have been deemed

reliable for the purposes for which they are used in the lethal injection procedure. The Human Rights Committee specifically expressed concern regarding "reports about the administration, by some states, of untested lethal drugs to execute prisoners and the withholding of information about such drugs. " ICCPR Concluding Observations, para. 8. The Committee suggested that execution practices such as those Oklahoma endorses violate Article 7 of the ICCPR, among other provisions of the treaty. The Committee recommended that the United States "[e]nsure that lethal drugs used for executions originate from legal regulated sources, and are approved by the FDA and that information on the origin and composition of such drugs is made available to individuals scheduled for execution. " *Id.* Midazolam is not FDA-approved for use as a stand-alone anesthetic, and therefore cannot meet this standard.

The ICCPR requires governments that have ratified the treaty to implement human rights standards that are consistent with the treaty's mandates. ICCPR, art. 2. Oklahoma's continued use of its current lethal injection protocol amounts to scientific or medical experimentation on prisoners, in violation of the United States' international law obligations under Article 7 of the ICCPR.

II. International law provides persuasive authority for interpreting the constitutional issues before this Court.

This Court has long recognized international law as a persuasive source of authority for questions arising under the U.S. Constitution and has often looked to international and comparative law and practice in its analysis of the Eighth Amendment's prohibition against cruel and unusual punishment. U.S. Const. amend. VIII. Whether a punishment is "cruel and unusual" is a determination informed by "evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, 356 U.S. at 101. In *Roper v. Simmons*, this Court held that execution of individuals for crimes committed as juveniles is a disproportionate punishment that violates the Eighth Amendment. In reaching its decision, the Court looked "to the laws of other countries and to international authorities as instructive for its interpretation of the Eighth Amendment's prohibition of 'cruel and unusual punishments.'" *Roper v. Simmons*, 543 U.S. 551, 575 (2005) (citing *Trop*, 356 U.S. at 102-103). More recently, in *Graham v. Florida*, the Court affirmed the relevance of international law to the proper interpretation of the Eighth Amendment. In its analysis of the constitutionality of Florida's juvenile life without parole policies, the Court examined the practices of other countries in sentencing juveniles, continuing the Court's "longstanding practice in noting the global consensus against the sentencing practice in question." *Graham v. Florida*, 560 U.S. 48, 80 (2010). The Court noted that even in the absence of on-point international law binding on the United States, international law, agreements, and practices are "relevant to the Eighth Amendment ... because the judgment of the world's nations that a particular

sentencing practice is inconsistent with basic principles of decency demonstrates that the Court's rationale has respected reasoning to support it." *Id.* at 82.

Significantly, with regard to the constitutional issues here, this Court has consulted and cited international authorities and the practices and decisions of other nations in assessing whether domestic practices comport with evolving standards of decency in the treatment of condemned prisoners.[11] International law and practice are particularly relevant in this case in light of the legal obligations binding on the United States, which prohibit non-consensual medical and scientific experimentation on prisoners and methods of execution that cause unnecessary suffering, in violation of the prohibition on cruel, inhuman, or degrading punishment.

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[11] *See, e.g., Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002), (examining the opinions of "the world community" to support its conclusion that execution of persons with severe intellectual disabilities would offend the standards of decency required by the Eighth Amendment); *Thompson v. Oklahoma*, 487 U.S. 815, 830-31 (1988) (Stevens, J.) (looking to the opinions and practices of "other nations that share our Anglo-American heritage" and "leading members of the Western European community" as aids to the proper interpretation of the Eighth Amendment). This Court has also found international law relevant to the interpretation of other constitutional provisions. *See Lawrence v. Texas*, 539 U.S. 558 (2003) (referencing a decision of the European Court of Human Rights to determine that a Texas sodomy law violated plaintiff's privacy rights under the due process clause of the Fourteenth Amendment); *Grutter v. Bollinger*, 539 U.S. 306, 344 (2003) (Ginsburg, J., concurring, joined by Breyer, J.) (noting that the Court's opinion with regard to affirmative action "accords with the international understanding of the office of affirmative action" reflected in four international treaties).

The ICCPR and the Torture Convention reflect the collaborative efforts of international human rights experts—with leadership from representatives of the United States[12]—to develop standards that will help maturing societies to build and maintain strong human rights practices. Those standards include prohibitions on torture and cruel, inhuman, and degrading treatment or punishment, as well as on non-consensual scientific and medical experimentation on human beings. Oklahoma's lethal injection protocol fails to comply with the human rights standards recognized in the ICCPR and in the Torture Convention, and therefore offends the evolving standards of decency that the United States recognized when it ratified those treaties.

CONCLUSION

Oklahoma's lethal injection procedure does not comply with international human rights standards that require that executions be performed with the minimum possible suffering and that governments refrain from non-consensual medical experimentation on human beings. The recent botched executions of Clayton Lockett, Joseph Wood, and Dennis McGuire, who visibly struggled and in the case of Lockett appeared to regain consciousness following the administration of midazolam, and who apparently experienced excruciating pain, illustrate the substantial risk of relying on midazolam as a stand-

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[12] *See, e.g.*, Boulesbaa, at 6, 20, 25 (describing the United States' role in the UN Human Rights Commission's Working Group tasked with drafting the Torture Convention); Jeffrey L. Dunoff et al., International Law Norms, Actors, Process: A Problem-Oriented Approach (3d Ed.) (2010), at 436.

alone anesthetic. This Court should consider the provisions of treaties that the United States has ratified and the views of their respective treaty monitoring bodies in determining whether Oklahoma's protocol can survive *Baze*'s rigorous constitutional scrutiny.

To proceed with executions using Oklahoma's lethal injection protocol offends the "evolving standards of decency" expressed by the treaties and endorsed by the many governments that are parties to those treaties. Because the United States has ratified the Torture Convention and the ICCPR, it has an obligation to exercise its moral authority to respect and strengthen the standards of decency they embody.

To assert that these international human rights standards are irrelevant to this Court's analysis would undermine the United States' important leadership in recognizing the standards of decency embodied in the Torture Convention and the ICCPR. When the United Nations General Assembly adopted the Torture Convention by consensus in 1984, U.S. representative to the UN Commission for Human Rights Richard Schifter praised the vote as a "significant achievement" demonstrating that "[i]t is no longer acceptable, in the eyes of the international community, for a government to claim that the way it treats its own citizens is solely an internal matter if the treatment in question violates the provisions of international instruments which set human rights standards." U.N. GAOR, 38th Sess., 93d plan. Mtg., at 1667, U.N. Doc. A/39/PV.93 (1984).

Human rights law forbids execution methods that result in unnecessary suffering as well as any

form of medical or scientific experimentation on prisoners. Allowing Oklahoma to proceed with its protocol for executing Petitioners is inconsistent with the United States' obligations under international human rights law as provided by the ICCPR and the Torture Convention.

For the foregoing reasons, the Court should find Respondents' proposed protocol unconstitutional under the Eighth Amendment and reverse the decision of the U.S. Court of Appeals for the 10th Circuit.

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RICHARD E. GLOSSIP, ET AL.,
Petitioners,
v.
KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Tenth Circuit

BRIEF FOR ALABAMA, ARIZONA, ARKANSAS, COLORADO, CONNECTICUT, GEORGIA, IDAHO, LOUISIANA, NEVADA, TENNESSEE, TEXAS, UTAH, & WYOMING AS AMICI CURIAE SUPPORTING RESPONDENTS

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QUESTIONS PRESENTED

1. Does a three-drug lethal injection protocol create a substantial risk of severe pain in violation of the Eighth Amendment when the first drug is highly likely to render the offender unconscious and insensate during the remainder of the execution procedure?

2. Does the *Baze*-plurality stay standard apply when states are not using a protocol substantially similar to the one that this Court considered in *Baze*?

3. When bringing an Eighth Amendment challenge to a method of execution under 42 U.S.C. § 1983, must a claimant establish the availability of an alternative method of execution?

TABLE OF CONTENTS

Questions Presented i

Table of Authorities iii

Interest of Amici Curiae 1

Summary of the Argument 2

Argument 3

I. The Court should uphold the constitutionality of Oklahoma's three-drug protocol 3

II. States began to use midazolam because it is effective and other lethal injection chemicals became difficult to obtain 5

A. Because of artificial shortages of other drugs, some states began to use midazolam 6

B. Midazolam has worked for 12 humane executions 8

III. No matter what states do, offenders challenge state execution methods as an additional way to postpone or halt lawful executions 15

A. David Larry Nelson 16

B. Thomas Arthur 18

Conclusion 21

TABLE OF AUTHORITIES

Cases

Arthur v. Ala. Dep't of Corr.,
285 F. App'x 705 (11th Cir. 2008) 19

Arthur v. Allen,
248 F. App'x 128 (11th Cir. 2007), *cert. denied* 553 U.S. 1004 (2008) 19

Arthur v. Allen,
452 F.3d 1234 (11th Cir. 2006), *cert. denied*, 549 U.S. 1338 (2007) 18

Arthur v. King,
500 F.3d 1335 (11th Cir. 2007) 18

Arthur v. State,
71 So. 3d 733 (Ala. Crim. App. 2010) 18

Arthur v. State,
820 So. 2d 886 (Ala. Crim. App. 2001) 18

Arthur v. Thomas,
674 F.3d 1257 (11th Cir. 2012) 20

Arthur v. Thomas,
739 F.3d 611 (11th Cir. 2014) 18

Banks v. State,
150 So. 3d 797 (Fla. 2014) 13

Baze v. Rees,
553 U.S. 35 (2008) ..... passim

Chavez v. Fla. SP Warden,
742 F.3d 1267 (11th Cir. 2014) 6

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832 So. 2d 730 (Fla. 2002) 10

Davis v. State,
875 So. 2d 359 (Fla. 2003) 12

Gissendaner v. Comm'r, Ga. Dep't of Corr.,
779 F.3d 1275 (11th Cir. 2015) 4, 5

Gregg v. Georgia,
428 U.S. 153 (1976) 1

Happ v. State,
922 So. 2d 182 (Fla. 2005) 9

Hendrix v. State,
136 So. 3d 1122 (Fla. 2014) 12

Henry v. State,
134 So. 3d 938 (Fla. 2014) 11

Henry v. State,
948 So. 2d 609 (Fla. 2006) 12

Hill v. McDonough,
547 U.S. 573 (2006) 4, 15

Howell v. State,
109 So. 3d 763 (Fla. 2013) 11

Kimbrough v. State,
886 So. 2d 965 (Fla. 2004) 9

Knight v. State,
923 So. 2d 387 (Fla. 2005) 10

Kormondy v. State,
154 So. 3d 341 (Fla. 2015) 13

Muhammad v. Florida,
132 So. 3d 176 (Fla. 2013) 7, 9

Nelson v. Campbell,
541 U.S. 637 (2004) 16, 17

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Statutes

18 Pa. Const. Stat. Ann. § 1102 1

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Miss. Code Ann. § 97-3-21 1
Mo. Rev. Stat. § 565.020 1
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Neb. Rev. Stat. § 28-303 1
Neb. Rev. Stat. § 29-2519–2524 1
Nev. Rev. Stat. § 200.030 1
Ohio Rev. Code Ann. § 2929.04 1
Okla. Stat. Ann. tit. 21, § 701.9 1
Or. Rev. Stat. § 163.105 1
S.C. Code Ann. § 16-3-20 1
S.D. Codified Laws § 23A-27A-4 1
Tenn. Code Ann. § 39-13-204 1
Tex. Penal Code Ann. § 12.31 1
Utah Code Ann. § 76-3-206 1
Va. Code Ann. § 18.2-10 1
Vt. Stat. Ann. tit. 13, § 3401 1
Wash. Rev. Code Ann. § 10.95.030 1
Wyo. Stat. Ann. § 6-2-101 1

Rules

Sup. Ct. R. 37 1

Other Materials

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2005 O.J. (L 200) 6

2011 O.J. (L 338) 6

Arek Sarkissian, *Kormondy executed for 1993 killing*, Ocala Star Banner, Jan. 15, 2015 13

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Arthur v. Thomas, No. 11-438, Doc. 159 (M.D. Ala. Sept. 30, 2013).....20

Arthur v. Thomas, No. 11-438, Doc. 195 (M.D. Ala. Jan. 1, 2015) 20

Arthur v. Thomas, No. 11-438, Doc. 197 (M.D. Ala. Jan. 7, 2015) 5, 20

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Florida Department of Corrections, *Execution List*.....9

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Glenn Puit and Parker Perry, *Charles Warner executed in Oklahoma without incident*, McAlester News-Capital, Jan. 15, 2015.....14

Grayson v. Sharp, et al., 2:12-cv-316-WKW (M.D. Ala.).....20

Hunt v. Myers, et al., 2:14-cv-1030-WKW (M.D. Ala.).....20

Jay Weaver and David Ovalle, *Juan Carlos Chavez executed for murder of Jimmy Ryce*, Miami Herald, Feb. 12, 2014.....10

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Jeff Schweers, *Many family members witness Hendrix's execution*, Ocala Star Banner, Apr. 23, 2014.....12

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Karl Etters, *Update: Banks executed for 1992 double murder*, Tallahassee Democrat, Nov. 14, 2014.....13

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Oklahoma Department of Public Safety, *The Execution of Clayton D. Lockett* 8, 14

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INTEREST OF AMICI CURIAE

A majority of states, as well as the federal government, impose capital punishment as a sentence for the worst murders.[1] *See Baze v. Rees*, 553 U.S. 35, 47 (2008) (plurality opinion); *Gregg v. Georgia*, 428 U.S. 153, 177 (1976) (plurality opinion). The *amici* states have an interest in executing offenders sentenced to this punishment through means that are humane, effective, and available.[2]

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[1] Ala. Code §§ 13A-5-39(1), 13A-5-40; Ariz. Rev. Stat. Ann. § 13-751; Ark. Code Ann. § 5-4-615; Cal. Penal Code §§ 190, 190.2; Colo. Rev. Stat. § 18-1.3-1201; Conn. Gen. Stat. § 53a-46a; Del. Code Ann. tit. 11, § 4209; Fla. Stat. Ann. § 921.141; Ga. Code Ann. § 16-5-1; Idaho Code Ann. § 19-2515; Ind. Code § 35-50-2-3; Kan. Stat. Ann. § 21-6617; Ky. Rev. Stat. Ann. § 532.030; La. Code Crim. Proc. Ann. art. 905; Miss. Code Ann. § 97-3-21(3); Mo. Rev. Stat. § 565.020; Mont. Code Ann. §45-5-102; Neb. Rev. Stat. §§ 28-303, 29-2519–2524; Nev. Rev. Stat. § 200.030; N.H. Rev. Stat. § 630:1; N.C. Gen. Stat. Ann. § 15A-2000; Ohio Rev. Code Ann. § 2929.04; Okla. Stat. Ann. tit. 21, § 701.9; Or. Rev. Stat. § 163.105; 18 Pa. Const. Stat. Ann. § 1102(a)(1); S.C. Code Ann. § 16-3-20; S.D. Codified Laws § 23A-27A-4; Tenn. Code Ann. § 39-13-204; Tex. Penal Code Ann. § 12.31; Utah Code Ann. § 76-3-206; Va. Code Ann. § 18.2-10(a); Wash. Rev. Code Ann. § 10.95.030; Wyo. Stat. Ann. § 6-2-101; 18 U.S.C. § 3591. *See also* Vt. Stat. Ann. tit. 13, § 3401 (making treason punishable by death).

[2] The *amici* States do not need consent of the parties to file this brief. *See* Sup. Ct. R. 37(4).

SUMMARY OF THE ARGUMENT

Extensive litigation over every element of lethal injection protocols has frustrated, delayed, or halted executions throughout the United States. The *amici* states urge this Court to adopt Justices Thomas and Scalia's view of the Eighth Amendment and hold that it prohibits only punishments deliberately designed to inflict pain. At the very least, the *amici* states urge this Court to enforce the *Baze* plurality's standard for all challenges to execution methods, allowing states to carry out constitutional capital sentences without being mired in interminable litigation. The only sensible and effective way to resolve this litigation is to *strictly* require plaintiffs to present an acceptable, available alternative to the state's protocol, and to hold plaintiffs to their proposed remedy. That requirement is the only thing that will prevent suits under 42 U.S.C. § 1983 from being anything other than habeas claims in disguise.

The states have adopted lethal injection protocols that, as a first step, render the offender unconscious. Many states began using sodium thiopental for this purpose, and later pentobarbital. But when the political opponents of capital punishment successfully pressured drug manufacturers to make those drugs unavailable, states looked to other, equally effective alternatives. This search led some states to midazolam: a drug that causes unconsciousness and prevents an offender from experiencing pain during an execution. And midazolam has done just that in twelve executions, under the same three-drug protocol Oklahoma uses.

For their part, death row inmates have sued about nearly every aspect of lethal injection, no matter what drugs were involved. This litigation should surprise no one; these lawsuits, although proceeding under § 1983, are thinly veiled attempts to prevent an offender's execution by *any* method. By filing § 1983 lawsuits without proposing any feasible alternative method of execution, inmates have turned the "courts into boards of inquiry charged with determining 'best practices' for executions, with each ruling supplanted by another round of litigation touting a new and improved methodology." *Baze*, 553 U.S. at 51.

ARGUMENT

I. The Court should uphold the constitutionality of Oklahoma's three-drug protocol.

Inmate challenges to execution methods have ground executions to a halt in many states. The *amici* states urge this Court to close the litigation floodgates and affirm the constitutionality of Oklahoma's three-drug protocol. It should do so in one of two ways.

First, the Court should explicitly adopt the standard Justices Thomas and Scalia proposed in *Baze*: "a method of execution violates the Eighth Amendment only if it is deliberately designed to inflict pain." *Id.* at 94 (Thomas, J., concurring). None of the states use a method of execution that is

designed to torture offenders or inflict "pain for the sake of pain." *See id.* at 48 (plurality opinion). It is undisputed that Oklahoma's protocol is constitutional under this standard.

Second, and at the very least, the Court should strictly require offenders who are challenging a method of execution to propose a "feasible[and] readily implemented" alternative that alleviates "a substantial risk of severe pain." *Id.* at 52 (plurality opinion). The plurality opinion in *Baze* rightly recognized that plaintiffs in a § 1983 case must proffer an alternative execution method that is both effective and available to the particular state the offender has sued. Only at that point, "[i]f a state refuses to adopt such an alternative . without a legitimate penological justification for adhering to its current method of execution, then a state's refusal to change its method can be viewed as 'cruel and unusual' under the Eighth Amendment." *Id.* If an offender proposes no alternative, then there is nothing for a state to do and nothing for a court to evaluate. *See Gissendaner v. Comm'r, Ga. Dep't of Corr.*, 779 F.3d 1275, 1283 (11th Cir. 2015) (affirming dismissal for failure to state a claim because the offender failed to plead an alternative execution method). The proposed remedy in a § 1983 case cannot be "no execution." *See Hill v. McDonough*, 547 U.S. 573, 580–81 (2006).

Petitioners have never identified an alternative to midazolam that they would not also challenge. Although they have recently hinted that compounded pentobarbital is an available alternative, Br. of Petitioners at 47, they have refused to concede that

they would accept that protocol were it adopted. And, as explained below, a switch to compounded pentobarbital may not be a feasible alternative for all states and would not end these kinds of lawsuits in any event. *See, e.g.*, *Gissendaner*, 779 F.3d 1275 (challenging the use of compounded pentobarbital); *Arthur v. Thomas*, No. 11-438, Docs. 1 (Jun. 8, 2011) (challenging Alabama's substitution of pentobarbital for sodium thiopental) & 197 (Jan. 7, 2015) (amending complaint to challenge Alabama's substitution of midazolam for pentobarbital) (M.D. Ala.).

The Court should either follow Justice Thomas's opinion in *Baze* or strictly and explicitly require plaintiffs to propose a feasible alternative method of execution. The experience of the States underscores that, under either standard, the court of appeals should be affirmed.

II. States began to use midazolam because it is effective and other lethal injection chemicals became difficult to obtain.

States began to use midazolam because of a drug shortage, and it has been successfully used in a three-drug combination identical to Oklahoma's for at least 12 executions. When *Baze* was decided, nearly all states carrying out lethal injections used sodium thiopental. *Baze*, 553 U.S. at 53. Since then, states have experienced increasing practical difficulties in obtaining sodium thiopental and alternatives like pentobarbital. Even the petitioners

recognize these difficulties. Br. of Petitioners at 5–8. The states' use of midazolam as a successful alternative—along with the well-known history of the drug shortages caused by the anti-death-penalty lobby—greatly undermines Petitioners' claim.

A. Because of artificial shortages of other drugs, some states began to use midazolam.

Several years ago, states began to have difficulty acquiring sodium thiopental and pentobarbital. Most of this difficulty was due to an artificial shortage caused by anti-death-penalty activists. *See, e.g.*, *Chavez v. Fla. SP Warden*, 742 F.3d 1267, 1273–75 (11th Cir. 2014) (Carnes, C.J., concurring). Many of the chemicals that states need for lethal injection are manufactured in European countries or by European-owned companies, and the European Union prohibits the export of such chemicals for use in capital punishment. 2011 O.J. (L 338) 31, 34. *See also* 2000 O.J. (C 364) 9 (banning capital punishment in the European Union); 2005 O.J. (L 200) 5 (prohibiting the export of devices that could be used in capital punishment). Foreign pharmaceutical companies devised distribution procedures to prevent any sales to prisons. *See, e.g.*, Press Release, Lundbeck, *Lundbeck overhauls pentobarbital distribution program to restrict misuse* (Jul. 1, 2011) (Lundbeck, Danish maker of pentobarbital).[3] And, in

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[3] Available at http://investor.lundbeck.com/releasedetail.cfm?ReleaseID=605775 (last visited Mar. 5, 2015).

recent years, other pharmaceutical companies have ceased manufacturing these chemicals in the United States. *See, e.g.*, Nathan Koppel, *Drug Halt Hinders Executions in the U.S.*, The Wall Street Journal, Jan. 22, 2011 (Hospira, U.S. maker of sodium thiopental).[4]

In response to these shortages, Florida developed the drug combination now used by Oklahoma, which calls for 500 milligrams of midazolam hydrochloride, followed by 200 milligrams of vecuronium bromide, then 120 milliequivalents of potassium chloride. Florida Department of Corrections, *Execution by Lethal Injection Procedures: Specific Procedures* (9)(f).[5] Midazolam effectively causes unconsciousness, preventing offenders from feeling pain. *See, e.g.*, *Muhammad v. Florida*, 132 So. 3d 176, 188 (Fla. 2013). As explained in more detail below, Florida has used this three-drug protocol to execute 11 inmates. After watching Florida successfully execute inmates without incident, Alabama and other states that were unable to obtain barbiturates began using midazolam as well. *See, e.g.*, *Roberts v. Meyers*, No. 14-1028, 2015 WL 1198666 at *1 (M.D. Ala. Mar. 16, 2015).

As states made changes to their drug protocols, many states also updated their procedures to prevent administration errors and ensure that executions are effective and practically pain-free. States require

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[4] Available at http://www.wsj.com/articles/SB10001424052748704754304576095980790129692 (last visited Mar. 5, 2015).

[5] Available at http://www.dc.state.fl.us/oth/deathrow/lethal-injection-procedures-as-of_01-09-15.pdf (last visited Mar. 3, 2015).

specific experience for execution team members. Before an execution, team members undergo comprehensive training, including practicing every element of an execution, as well as simulations to prepare for problems that could occur. States follow extensive procedures for obtaining and checking drugs for use in executions and for monitoring offenders before their execution dates. During the execution procedure itself, states observe protections for the offender, such as specific consciousness checks following the administration of the sedative. *See, e.g.*, *Baze*, 553 U.S. at 55–56; Oklahoma Department of Public Safety, *The Execution of Clayton D. Lockett* 13–14, 26–29;[6] Br. of Respondents at 16–17; *Arthur v. Allen*, No. 07-0722-WS-M, 2007 WL 4105113, at *2 (S.D. Ala. Nov. 15, 2007). Although human error can arise in the execution process, state procedures and the drugs themselves are adequate to ensure there is no substantial risk of severe pain.

B. Midazolam has worked for 12 humane executions.

At least 12 offenders have been successfully executed with the challenged drug protocol Florida has used its protocol to execute 11 offenders without incident. *See* Florida Department of Corrections,

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[6] Available at http://www.dps.state.ok.us/Investigation/14-0189SI%20Summary.pdf (last visited Mar. 24 (2015).

Execution List.[7] And Oklahoma has executed one. According to eyewitness accounts, these executions took an average of 14 minutes. Although some offenders apparently moved slightly during their executions, reviewing courts have concluded that this is not evidence of consciousness or suffering. *See, e.g.*, *Muhammad*, 132 So. 3d at 188. These practically painless executions provide real-world evidence of midazolam's effectiveness as a sedative. And they stand in marked contrast to the brutal murders that justified them.

1. *William Happ (October 15, 2013).* William Happ kidnapped Angie Crowley, raped her, and strangled her with her own pants. *Happ v. State*, 922 So. 2d 182, 183–84 (Fla. 2005). His execution lasted 14 minutes, during which he allegedly blinked and yawned, but he was completely nonresponsive when an official "tugged at his eyelids and grasped his shoulder." Associated Press, *Fla. executes man for Illinois woman's 1986 murder*, Tampa Tribune, Oct. 15, 2013.[8]

2. *Darius Kimbrough (November 12, 2013).* Darius Kimbrough raped Denise Collins, breaking her skull and jaw during the attack. *Kimbrough v. State*, 886 So. 2d 965, 968–69 (Fla. 2004). His execution lasted 17 minutes, and he lay motionless the whole time. Susan Jacobson, *Darius Kimbrough,*

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[7] Available at http://www.dc.state.fl.us/oth/deathrow/execlist.html (last visited Mar. 3, 2015).

[8] Available at http://tbo.com/news/crime/happ-to-be-executed-today-for-1986-citrus-county-murder-20131015/ (last visited Mar. 11, 2015).

who killed Orange County woman, is executed, Orlando Sentinel, Nov. 12, 2013.[9]

3. *Thomas Knight (January 7, 2014).* Thomas Knight kidnapped Sydney and Lillian Gans, forced them to withdraw $50,000 at a bank, and shot each of them in the neck. *Knight v. State*, 923 So. 2d 387, 389 (Fla. 2005). While on death row for that crime, Knight stabbed corrections officer James Burke to death with a sharpened spoon. *Id.* at 389 n.1. His execution lasted 14 minutes; a reporter observed that he "seemed to drift into slumber." David Ovalle, *Thomas Knight, who killed Miami couple and a prison guard, executed*, Miami Herald, Jan. 7, 2014.[10]

4. *Juan Carlos Chavez (February 12, 2014).* Juan Carlos Chavez kidnapped and raped nine-year-old Jimmy Ryce, shot him in the back as he tried to escape, and later dismembered his body. *Chavez v. State*, 832 So. 2d 730, 736–41 (Fla. 2002). Chavez's execution lasted 15 minutes, during which time he may have "moved his feet." *See* Jay Weaver and David Ovalle, *Juan Carlos Chavez executed for murder of Jimmy Ryce*, Miami Herald, Feb. 12, 2014;[11] *Juan Carlos Chavez, Killer of Jimmy Ryce,*

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[9] Available at http://articles.orlandosentinel.com/2013-11-12/news/os-execution-darius-kimbrough-florida-20131112_1_darius-kimbrough-orange-county-woman-denise-collins (last visited Mar. 11, 2015).

[10] Available at http://www.miamiherald.com/news/local/community/miami-dade/article1959035.html (last visited Mar. 11, 2015).

[11] Available at http://www.miamiherald.com/news/state/article1960281.html (last visited Mar. 11, 2015).

Executed at Florida State Prison, NBCMiami, Feb. 13, 2014.[12]

5. *Paul Howell (February 26, 2014).* Paul Howell killed state trooper Jimmy Fulford with a pipe bomb while trying to deliver it to someone else. *Howell v. State*, 109 So. 3d 763, 765–66 (Fla. 2013). Howell's execution lasted 14 minutes, during which he may have opened his eyes. Jeff Burlew, *Howell apologizes to family before execution*, Tallahassee Democrat, Feb. 27, 2014.[13]

6. *Robert Henry (March 20, 2014).* Robert Henry beat Phyllis Harris and Janet Thermidor with a hammer and set them on fire while robbing a fabric store. *Henry v. State*, 134 So. 3d 938, 940 (Fla. 2014). His execution lasted 11 minutes, during which he may have blinked and moved his lips. *See* Brittany Wallman, *Broward killer apologizes, then speaks against death penalty before execution*, Sun Sentinel, Mar. 20, 2014;[14] Associated Press, *Fla. Man executed*

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[12] Available at http://www.nbcmiami.com/news/Execution-of-Juan-Carlos-Chavez-Killer-of-Jimmy-Ryce-Scheduled-for-Wednesday-245177101.html (last visited Mar. 11, 2015).

[13] Available at http://www.tallahassee.com/story/politics/2014/02/27/howell-apologizes-to-family-before-execution/5854789/ (last visited Mar. 11, 2015).

[14] Available at http://articles.sun-sentinel.com/2014-03-20/news/fl-robert-henry-execution-20140320_1_death-penalty-robert-lavern-henry-florida-state-prison (last visited Mar. 11, 2015).

for fatal beating, burning of two women, CBSNews.com, Mar. 21, 2014.[15]

7. *Robert Hendrix (April 23, 2014).* Robert Hendrix stabbed and shot Elmer and Michelle Scott to prevent Elmer from testifying in a burglary trial. *Hendrix v. State*, 136 So. 3d 1122, 1124 (Fla. 2014). His execution lasted 11 minutes and was uneventful. Jeff Schweers, *Many family members witness Hendrix's execution*, Ocala Star Banner, Apr. 23, 2014.[16]

8. *John Henry (June 18, 2014).* John Henry killed his wife, Suzanne, by stabbing her to death. He then kidnapped her son, Eugene Christian, stabbed him to death, and left his body in a field. *Henry v. State*, 948 So. 2d 609, 612 (Fla. 2006). Henry's execution lasted 11 minutes, during which he "softly" moved his lips before "clos[ing] his eyes and [becoming] motionless." Associated Press, *Florida man becomes 3rd executed in US in 24 hours*, CBSNews.com, Jun. 18, 2014.[17]

9. *Eddie Davis (July 10, 2014).* Eddie Davis kidnapped and raped an 11-year-old girl, Kimberly Ann Waters, suffocated her with plastic, and discarded her body in a trash can. *Davis v. State*, 875 So. 2d 359, 363 (Fla. 2003). Davis's execution lasted

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[15] Available at http://www.cbsnews.com/news/florida-man-executed-for-fatal-beating-burning-of-two-women/ (last visited Mar. 11, 2015).

[16] Available at http://www.ocala.com/article/20140423/ARTICLES/140429846?p=1&tc=pg (last visited Mar. 11, 2015).

[17] Available at http://www.cbsnews.com/news/florida-man-becomes-3rd-executed-in-us-in-24-hours/ (last visited Mar. 11, 2015).

11 minutes, and he "showed no signs of discomfort." Suzie Schottelkotte, *Eddie Wayne Davis Executed for Rape, Murder of 11-Year-Old Lakeland Girl*, The Ledger, Jul. 10, 2014.[18]

10. *Chadwick Banks (November 13, 2014).* Chadwick Banks shot his wife, Cassandra, and his ten-year-old stepdaughter, Melody Cooper. *Banks v. State*, 150 So. 3d 797, 798 (Fla. 2014). His execution lasted 17 minutes and was uneventful. Karl Etters, *Update: Banks executed for 1992 double murder*, Tallahassee Democrat, Nov. 14, 2014.[19]

11. *Johnny Kormondy (January 15, 2015).* Johnny Kormondy, along with others, repeatedly raped Cecelia McAdams and shot her husband, Gary McAdams, in the head. *Kormondy v. State*, 154 So. 3d 341, 343–44 (Fla. 2015). His execution lasted 11 minutes, during which his chest apparently "heaved" and "his jaw dropped." Arek Sarkissian, *Kormondy executed for 1993 killing*, Ocala Star Banner, Jan. 15, 2015.[20]

12. *Charles Warner (January 15, 2015).* Charles Warner raped and killed an 11-month old girl. *Warner v. State*, 144 P.3d 838, 856 (Okl. 2006). His execution lasted 18 minutes. Glenn Puit and Parker Perry, *Charles Warner executed in Oklahoma without*

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[18] Available at http://www.theledger.com/article/20140710/news/140719989 (last visited Mar. 11, 2015).

[19] Available at http://www.tallahassee.com/story/news/2014/11/12/familys-wait-justice-may-end-tonight/18926403/ (last visited Mar. 11, 2015).

[20] Available at http://www.ocala.com/article/20150115/ARTICLES/150119794 (last visited Mar. 17, 2015).

incident, McAlester News-Capital, Jan. 15, 2015.[21] Although he reportedly said, "It feels like acid," before the three-drug cocktail was administered, Warner did not suffer after the midazolam took effect. *Id.*

* * *

Given this history, Petitioners cannot show that Oklahoma's protocol comes with a substantial risk of severe pain. Nor have they identified any readily available alternative to midazolam. In fact, midazolam itself may not even be available much longer. *See* Tracy Connor, *Drug-Maker Akorn Bans Sedative Midazolam for Executions*, Feb. 19, 2015.[22]

Of course, not every midazolam-based execution has been uneventful. But administration errors can occur regardless of the drug combination used. And such errors should lead to the adoption of additional safeguards and procedures, not the wholesale abandonment of successful drug protocols. *See* Oklahoma Department of Public Safety, *The Execution of Clayton D. Lockett*, supra at 8. The fact remains that midazolam is the one of the best drugs the states have available to render an inmate unconscious.

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[21] Available at http://www.mcalesternews.com/news/the-state-of-oklahoma-carried-out-the-execution-of-charles/article_b751aefc-9d27-11e4-a69b-b347f82c06c6.html (last visited Apr. 6, 2015).

[22] Available at http://www.nbcnews.com/storyline/lethal-injection/drug-maker-akorn-bans-sedative-midazolam-executions-n309191 (last visited Apr. 2, 2015).

III. No matter what states do, offenders challenge state execution methods as an additional way to postpone or halt lawful executions.

While facing drug shortages, states have been forced to defend against a host of litigation about their new procedures. As Justice Thomas predicted in *Baze*, death row inmates have used § 1983 to "embroil the States in never-ending litigation concerning the adequacy of their execution procedures." *Baze*, 553 U.S. at 105 (Thomas, J., concurring). In fact, just this February, Yale's Ethics Bureau admitted to this Court that the very reason for such lawsuits is delay. The Bureau explained that "[t]he very goal[] of the client's representation" in a challenge to an execution protocol is "preventing the client's execution." Brief for the Ethics Bureau at Yale as amicus curiae supporting Petitioner at 6, *Storey v. Lombardi*, No. 14-8362 (U.S. Feb. 9, 2015). The brief expressly confirms what the states have known—and told this Court—all along: "the principal goal of any lawyer representing a death row client is to prevent his client's execution." *Id.* at 7.

There is no execution method or drug protocol that the states can adopt to stanch the flood of litigation, unless this Court strictly requires plaintiffs to identify a readily available alternative to the state's method of execution. The states have consistently argued that these suits are really habeas petitions in disguise. *See Hill*, 547 U.S. at 581; Br. for Alabama, et al. as amici curiae in

Support of Respondents, *id.*, 2006 WL 927239; *Nelson v. Campbell*, 541 U.S. 637, 644–45 (2004); Br. for Ohio, et al. as amici curiae in Support of Respondents, *id.*, 2004 WL 553654. But even if these lawsuits could be construed as good faith litigation over execution best practices, a majority of this Court has recognized the inadvisability of courts sitting as boards of inquiry over execution procedures. *Baze v. Rees*, 553 U.S. at 51 (opinion of Roberts, C.J., joined by Kennedy, J., and Alito, J.), 69–71 (Alito, J., concurring), 105–06 (Thomas, J., concurring, joined by Scalia, J.). Alabama's experience shows courts are doing precisely that.

A. David Larry Nelson

Before this Court decided *Hill*, Alabama and 25 other states explained that "[i]n the real world, there is no meaningful distinction between [challenging an execution procedure and challenging an execution *per se*], and experience shows that an inmate can block an execution just as surely by challenging a 'procedure' as by challenging his sentence directly." Br. of Alabama, et al. in support of Respondents, *Hill*, 547 U.S. 573, 2006 WL 927239; *see also* Br. for the Ethics Bureau at Yale at 6-7, *Storey v. Lombardi*, No. 14-8362 (U.S. Feb. 9, 2015). Alabama presented a case study of this interminable litigation in David Larry Nelson. Br. for Alabama, et al. at *4-14, *Hill*, 547 U.S. 573, 2006 WL 927239. As the states predicted, his case dragged on after this Court decided *Hill*.

After convincing Wilson W. Thompson to have an "orgy" with him and his girlfriend, Linda Vice, Nelson shot and killed Thompson as Thompson began performing oral sex on Vice. Nelson then shot Vice and drove away in Thompson's car. *Nelson v. State*, 511 So. 2d 225, 229 (Ala. Crim. App. 1986). Once his post-conviction proceedings were over, Nelson challenged the state's proposed cut-down procedure that would enable it to access his veins and conduct a lethal injection. *Nelson*, 541 U.S. at 639. This Court permitted his § 1983 suit to go forward. *See id.*

On remand, when the state agreed to use the alternative procedure proposed by Nelson, Nelson's lawyers then challenged that alternative procedure on essentially the same grounds. *See* Br. of Alabama, et al. at *8-9, *Hill*, 2006 WL 927239. The district court permitted Nelson to file an amended complaint challenging the procedure he had supported in his first complaint and referred the case to a medical expert. *Nelson*, No. 03-1008, Docs. 60 (Apr. 22, 2005) & 83 (Jul. 28, 2006) (M.D. Ala.).

And Nelson's case remained pending long after that. The district court had yet to rule on the state defendants' May 2008 summary judgment motion when Nelson died in the prison infirmary of "natural causes" in November 2009, 27 years after his sentence was originally imposed. *Nelson v. Campbell*, No. 03-1008, Docs. 159 (May 15, 2008) & 174 (Dec. 3, 2009) (M.D. Ala.); Connie Baggett, *Death*

row inmate David Larry Nelson dies in Holman infirmary, Al.com, Nov. 3, 2009.[23]

B. Thomas Arthur

Thomas Arthur's litigation tactics similarly illustrate the states' experience. Arthur fatally shot Troy Wicker through the right eye, and his conviction and death sentence became final in 1998. *Arthur v. Thomas*, 739 F.3d 611, 618 (11th Cir. 2014). Arthur is well-known to state and federal courts in Alabama as a frequent filer of lawsuits, ranging from untimely post-conviction litigation to attempted fraud on the lower courts by orchestrating and filing a patently false affidavit from a fellow inmate. *See id.* at 612–27 (recounting the 30-year history of Arthur's criminal litigation); *Arthur v. State*, 820 So. 2d 886 (Ala. Crim. App. 2001); *Arthur v. Allen*, 452 F.3d 1234 (11th Cir. 2006), *cert. denied*, 549 U.S. 1338 (2007); *Arthur v. State*, 71 So. 3d 733 (Ala. Crim. App. 2010); *Arthur v. King*, 500 F.3d 1335, 1338-39 (11th Cir. 2007).

Both before and after this Court decided *Baze*, Arthur filed multiple § 1983 actions challenging various aspects of Alabama's execution protocols.

1. After his post-conviction appeals were over, Arthur challenged the constitutionality of Alabama's protocol, which at that time was composed of sodium pentothal, pancuronium bromide, and potassium chloride. *Arthur v. Allen*, No. 07-0342, 2007 WL

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[23] Available at http://blog.al.com/live/2009/11/death_row_inmate_david_larry_n.html (last visited Mar. 18, 2015).

2320069 at *1 (S.D. Ala. Aug. 10, 2007) (unreported). The district court dismissed Arthur's lawsuit, concluding that he unreasonably delayed filing it, and the Eleventh Circuit affirmed. *Arthur v. Allen*, 248 F App'x 128 (11th Cir. 2007), *cert. denied* 553 U.S. 1004 (2008).

2. Arthur immediately filed another § 1983 lawsuit, challenging Alabama's consciousness check and procedures administering lethal injections and again criticizing Alabama's use of sodium thiopental. *Arthur v. Allen*, No. 07-0722, Doc. 1 at 11–12, 16–17 (S.D. Ala. Oct. 9, 2007). Noting that Arthur's second § 1983 lawsuit was essentially identical to his first, the district court dismissed it. *Arthur v. Allen*, 2007 WL 4105113 at *1–2 (S.D. Ala. Nov. 15, 2007). The Eleventh Circuit affirmed, noting Arthur's delay and the suit's redundancy. *Arthur v. Ala. Dep't of Corr.*, 285 F. App'x 705 (11th Cir. 2008) (unpublished).

3. A few years later, Arthur filed yet another § 1983 suit, this time challenging Alabama's substitution of pentobarbital for sodium thiopental in its three-drug protocol. *Arthur v. Thomas*, No. 11-438, Doc. 1 (M.D. Ala. Jun. 8, 2011). The district court summarily dismissed his complaint, reasoning that it was time-barred and relying on Eleventh Circuit precedent holding that Alabama's adoption of pentobarbital was not a significant change to its protocol. *Arthur*, No. 11-438, Doc. 37 (M.D. Ala. Nov. 3, 2011). But the Eleventh Circuit reversed, remanding for further proceedings to determine whether the change in protocol was significant and whether Alabama would fail to administer a consciousness check. *Arthur v. Thomas*, 674 F.3d

1257 (11th Cir. 2012). On remand, the district court held an evidentiary hearing, the state renewed its motion for summary judgment, and the court denied that motion. *Arthur*, No. 11-438, Doc. 159 (M.D. Ala. Sept. 30, 2013).

4. While that action was still pending, pentobarbital became unavailable to Alabama, and Alabama substituted midazolam for pentobarbital in its execution protocol. Arthur amended his complaint, essentially substituting "midazolam" for "pentobarbital" in his arguments that the first drug in the state's protocol would not render him sufficiently unconscious. *Arthur*, No. 11-438, Doc. 197 (M.D. Ala. Jan. 7, 2015). The parties began further discovery, but the district court stayed that action pending the outcome of this Court's decision in this case. *Arthur*, No. 11-438, Doc. 241 at 3–4 (Mar. 18, 2015).

As one district court noted, Arthur is "picking every apple on the litigation tree, including some green and rotten ones." *Arthur*, No. 11-438, Doc. 195 at 5 n.2 (Jan. 1, 2015). And he is not the only death row inmate in Alabama's orchard. *See Grayson v. Sharp, et al.*, 2:12-cv-316-WKW; *Frazier v. Myers, et al.*, 2:13-cv-781-WKW; *Boyd v. Myers, et al.*, 2:14-cv-1017-WKW; *Roberts v. Myers, et al.*, 2:14-cv-1028-WKW; *Myers v. Myers, et al.*, 2:14-cv-1029-WKW; *Hunt v. Myers, et al.*, 2:14-cv-1030-WKW.

* * *

The *amici* states have no interest in causing unnecessary pain during an execution. Far from

designing procedures to inflict pain, states choose the most humane and least painful methods possible to ensure a quick death. But when one method becomes unavailable, states must turn to another. The practical ability to carry out executions is "a legitimate penological justification" for using a particular execution method, including a three-drug protocol with midazolam. *Baze*, 553 U.S. at 52 (plurality opinion).

CONCLUSION

This Court should affirm the court of appeals.

Respectfully submitted,

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IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, et al.,

Petitioners,

vs.

KEVIN J. GROSS, et al.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF *AMICUS CURIAE* OF THE CRIMINAL JUSTICE LEGAL FOUNDATION IN SUPPORT OF RESPONDENTS

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QUESTIONS PRESENTED

1. Does a Federal District Court correctly deny an injunction against execution of a state prisoner in a § 1983 action when it finds, based on substantial evidence, that the plaintiffs have failed to establish that the protocol to be used is "sure or very likely" to cause severe pain?

2. Is the standard for a stay set forth in *Baze* v. *Rees* narrowly limited to execution protocols nearly identical to the one at issue in that case, or does it apply to any execution protocol alleged to create a risk of pain but not designed to cause pain?

3. When challenging an execution method alleged to create a risk of severe pain, must the prisoner show that there is an available alternative with a substantially lower risk?

TABLE OF CONTENTS

Questions presented i

Table of authorities v

Interest of *amicus curiae* 1

Summary of facts and case 2

Summary of argument 4

Argument 6

I

The Eighth Amendment does not require completely painless executions or "best practices," but a "risk" claim must consider alternatives 6

A. Not torturous, but not painless 6

B. The alternative problem 8

C. *Nelson* and *Hill* 11

D. *Baze*, risk, and alternatives 14

II

Any relief granted in a federal court should be the least intrusive possible, with injunction of the execution only as a last resort 20

III

The United States must not allow its justice to be obstructed by an antidemocratic and largely foreign conspiracy 22

IV

The national consensus is that capital punishment serves an important function and needs to be enforced . 28

Conclusion 32

TABLE OF AUTHORITIES

Cases

Baze v. Rees, 553 U. S. 35, 128 S. Ct. 1520, 170 L. Ed. 2d 420 (2008) . . . . . Passim

Farmer v. Brennan, 511 U. S. 825, 114 S. Ct. 1970, 128 L. Ed. 2d 811 (1994) 15, 16, 17

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Gomez v. Fierro, 519 U. S. 918, 117 S. Ct. 285, 136 L. Ed. 2d 285 (1996) 9

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114 S. Ct. 1921, 128 L. Ed. 2d 745 (1994) 14

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18 U. S. C. § 3626 20

18 U. S. C. § 3771 21

28 U. S. C. § 2254 13

28 U. S. C. § 2265 29

28 U. S. C. § 2283 20

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IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, et al.,

Petitioners,

vs.

KEVIN J. GROSS, et al.,

Respondents.

BRIEF *AMICUS CURIAE* OF THE CRIMINAL JUSTICE LEGAL FOUNDATION IN SUPPORT OF RESPONDENTS

INTEREST OF *AMICUS CURIAE*

The Criminal Justice Legal Foundation (CJLF)[1] is a non-profit California corporation organized to participate in litigation relating to the criminal justice system as it affects the public interest. CJLF seeks to bring the constitutional protection of the accused into balance with the rights of the victim and of society to rapid, efficient, and reliable determination of guilt and swift execution of punishment.

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1. Both parties have filed blanket consents to the filing of *amicus* briefs.

   No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae* CJLF made a monetary contribution to its preparation or submission.

This case is part of an effort to obstruct the execution of well-deserved sentences for the worst murderers, even when there is no doubt of guilt and even when the penalty determination has been thoroughly reviewed and found to be proper. Such obstruction is contrary to the interests of victims of crime that CJLF was formed to protect.

SUMMARY OF FACTS AND CASE

Four Oklahoma murderers sought a preliminary injunction against the use of Oklahoma's lethal injection protocol. J. A. 112. All four committed severely aggravated murders for which death is clearly a just punishment. Charles Warner anally raped and murdered the eleven-month-old daughter of his girlfriend. Richard Glossip hired another employee to beat their employer to death with a baseball bat. Benjamin Cole murdered his nine-month-old daughter by bending her in half backward, snapping her spine. J. A. 113-114. John Grant was already in prison for a *de facto* life sentence, and thus "judgment proof" from any sentence but death, when he murdered a prison food service supervisor, stabbing her 16 times with a "shank." *Grant* v. *State*, 58 P 3d 783, ¶¶ 2-6 (Okla. Crim. App. 2002). As of the date of the Court of Appeals opinion, "all four of the plaintiffs ha[d] exhausted their state and federal court remedies and the State of Oklahoma ha[d] established specific execution dates for each of them." J. A. 114.

Oklahoma for many years used a three-drug protocol for executions, with a barbiturate for the first drug, like the protocol upheld in *Baze* v. *Rees*, 553 U. S. 35, 44 (2008). When thiopental became unavailable, the state substituted another barbiturate, pentobarbital, but when that drug also became unavailable the state

substituted midazolam, "a sedative in the benzodiazepine family of drugs." J. A. 114-115. The present case is primarily a challenge to that substitution. After hearing expert testimony from both sides, the District Court denied the preliminary injunction.

> "I conclude on the basis of the evidence before me that plaintiffs have failed to establish that proceeding with the execution of these plaintiffs on the basis of the revised protocol presents a risk that is 'sure or very likely to cause serious illness and needless suffering,' amounting to 'an objectively intolerable risk of harm,' in the words of the Supreme Court at page 50 of the Baze decision." J. A. 96.

The Tenth Circuit affirmed. J. A. 111-112. This Court denied a stay of execution for Charles Warner by a 5-4 vote, see *Warner* v. *Gross*, 135 S. Ct. 824, 190 L. Ed. 2d 903 (2015), and Warner was executed.

Petitioners cite a press report that Warner said "my body is on fire." Brief for Petitioners 22. They omit the essential fact that a media witness also reported that Warner said this "*before* the three-drug cocktail was administered." DeLaTorre, Doney, and Broyles, Oklahoma Inmate Said His 'Body Was on Fire' Prior to Being Executed for 1997 Murder and Rape, KFOR (Jan. 16, 2015) (emphasis added).[2] That report continues,

> "His last words before the drugs took full effect were 'I'm not afraid to die, we's [we are] all gonna die.'

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2. http://kfor.com/2015/01/15/oklahoma-inmate-said-his-body-was-on-fire-prior-to-be-executed-for-1997-murder-and-rape/ (all Internet materials as visited April 8, 2015).

> "Broyles said it did not appear Warner was in pain. He never raised his head off the gurney and did not convulse the way Lockett did last April.
>
> "Sean Murphy with the Associated Press said afterwards, 'It appeared the sedative worked.' "

Warner's *pre*-injection "on fire" exclamation is not evidence that the Oklahoma protocol causes extreme pain. It is further evidence that there is a campaign of deception that extends to soliciting condemned inmates to fake agony in their last moments, and some are going along with it, though some are not. See Smyth, Public Defender Accused of Coaching Dennis McGuire to Exaggerate Suffocation During Execution, Associated Press (Jan. 27, 2014).[3]

This Court granted certiorari on January 23, 2015. On January 28, at the request of the State, the Court stayed executions using midazolam.

SUMMARY OF ARGUMENT

The Eighth Amendment does not allow torturous methods of execution but also does not require completely painless ones. The *Wilkerson/Kemmler* rule does not require an available alternative but only applies to methods that are intended to or certainly do cause extreme pain. The *Baze* standard is adapted from the prison conditions "deliberate indifference" cases and applies whenever the claim relates to a risk of pain. The *Baze* standard requires threshold showings of both severity and risk of pain, and it requires comparison to available alternatives.

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3. http://www.cleveland.com/nation/index.ssf/2014/01/public_defender_accused_of_coa.html.

When relief is required, the Prison Litigation Reform Act of 1995 requires that it be the least intrusive possible. In the context of a method-of-execution claim, an order requiring a specific, available alternative method instead of the state's proposed method is less intrusive than one that simply bars use of the state's method. Without an approval of a specified alternative, the state would have to start over, possibly delaying justice for years. In addition, it is doubtful whether a federal court in a § 1983 action has jurisdiction to issue an order that amounts in practice to an indefinite stay of execution. *Nelson* and *Hill* suggest that such an order may require conversion to a habeas petition, with all the limitations imposed on that form of action.

The present case has arisen only because of a restriction on the distribution of the preferred drugs for lethal injection, caused primarily by European companies under pressure from European governments. The people of the United States are entitled to decide through the democratic process whether to have capital punishment. We must not allow ourselves to be pressured and manipulated from Europe. A rule of law that says a state cannot proceed without the optimum drugs, when those drugs have been cut off from abroad, would facilitate an assault on our sovereignty and our democracy.

The consensus that is most relevant in this case is the consensus of the American people that capital punishment has an important place in our system of criminal justice and needs to be enforced. The fact that most states have not yet needed to select a replacement for barbiturates in their lethal injection protocols, because so far they have been able to obtain them or because executions are stalled for other reasons, does

not establish a "consensus" that midazolam is an unacceptable substitute.

ARGUMENT

I. The Eighth Amendment does not require completely painless executions or "best practices," but a "risk" claim must consider alternatives.

A. Not Torturous, But Not Painless.

To many Americans, the amount of hand-wringing over the risk of pain felt by murderers during execution seems very strange. For example, Petitioners and supporting *amici* make much of the fact that midazolam is not considered a proper drug to use as the sole anesthetic in surgery. See Brief for Petitioners 13; Brief of Sixteen Professors of Pharmacology as *Amici Curiae* 20.[4] John and Jane Public would likely say, "So what? This isn't supposed to be a medical procedure. It's supposed to be punishment."

By insisting that the state must use a drug that puts the inmate in a "comalike" state, see Brief for Petitioners 26, Petitioners are arguing in essence that a murderer is entitled to a completely painless execution. The Eighth Amendment requires no such thing, and *Baze* v. *Rees*, 553 U. S. 35 (2008), did not change that. There is a wide gulf between torturous and painless, and forbidding one does not equal requiring the other.

An *amicus* supporting Petitioners has again traced the familiar history of the evolution of methods of execution in the United States. See Brief for the Louis

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4. This brief is labeled as being in support of neither party. It actually attempts to support Petitioners.

Stein Center for Law and Ethics at Fordham University School of Law as *Amicus Curiae* ("Fordham Brief"); see also *Baze*, 553 U. S., at 42-43 (summarizing same history). The history does indeed show that our society has made an effort to make executions as painless as feasible. It does not follow, though, that executions must be completely painless. On the contrary, methods of execution continued to be used even though they were recognized to often be painful. Hangings continued throughout most of the nineteenth century, even though they were known to sometimes result in "slow strangulations." See Fordham Brief 5.

Wilkerson v. *Utah*, 99 U. S. 130 (1879), was a territorial case where the Eighth Amendment applied directly, even before "incorporation." "Cruel and unusual punishments are forbidden by the Constitution, but the authorities referred to are quite sufficient to show that the punishment of shooting . . is not included in that category within the meaning of the eighth amendment." *Id.*, at 134-135. No one could think that shooting is painless, and the *Wilkerson* Court did not require painlessness.[5] The constitutional prohibition was directed at "punishments of torture." *Id.*, at 136. Electrocution was adopted in the belief that it was a "more humane" method than the prior methods, primarily hanging. See *In re Kemmler*, 136 U. S. 436, 447 (1890). That is not to say it was completely painless or that painlessness was constitutionally required.

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5. Utah has recently reinstated the firing squad as an alternative, drawing surprising support from well known death penalty opponent Deborah Denno. See Lopez, Why Utah Is Bringing Back the Firing Squad for Executions, Vox (as of Mar. 27, 2015), http://www.vox.com/2015/3/27/8301357/utah-death-penalty.

> "Punishments are cruel when they involve torture or a lingering death; but the punishment of death is not cruel, within the meaning of that word as used in the Constitution. It implies there something inhuman and barbarous, something more than the mere extinguishment of life."[6] *Ibid.*

Pain is a part of life. All of us experience it at some time. Some people choose to endure pain as the price of participating in athletic activity. People often voluntarily endure pain during medical treatment or while recovering from it. People may choose to endure pain from medical conditions or in childbirth as preferable to taking the drugs that would be needed to be pain-free. We should not be so squeamish as to recoil in horror at the possibility that someone who has intentionally inflicted enormous suffering on innocent others might suffer some pain as an incidental consequence of receiving the punishment he richly deserves for his crime. The Court's decision in this case should permanently put to rest any notion that a murderer is constitutionally entitled to a completely painless death. See *Baze*, 553 U. S., at 104 (Thomas, J., concurring in the judgment) ("anesthetized"). Extreme or prolonged pain is the concern here, not any pain at all.

B. The Alternative Problem.

The idea that methods of execution must be judged relative to available alternatives is a relatively recent development, and it came from the defense side. The gas chamber had been regularly upheld against Eighth Amendment challenge from its introduction through the 1980s. See *State* v. *Gee Jon*, 46 Nev. 418, 435-437,

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6. To be sure, *Kemmler*'s discussion of the requirements of the Eighth Amendment is dictum. The holding is that the Eighth Amendment does not apply to a state case. *Id.*, at 447-448.

211 P. 676, 681-682 (1923); *Gray* v. *Lucas*, 710 F. 2d 1048, 1057-1061 (CA5 1983). In 1992, as California prepared to carry out its first post-*Furman* execution, the Ninth Circuit stayed the execution on an Eighth Amendment challenge to the gas chamber. This Court vacated the stay on the ground that the inmate, Robert Alton Harris, had abusively delayed a known claim to the last minute. *Gomez* v. *U. S. District Court*, 503 U. S. 653, 653-654 (1992) (*per curiam*), but two dissenting Justices agreed with the claim on the merits.

The *Gomez* dissenters agreed with the inmate's argument that "in light of the availability of more humane and less violent methods of execution, Harris' claim has merit." 503 U. S., at 654 (Stevens, J., dissenting). The alternative, endorsed by "numerous medical, legal, and ethical experts," *id.*, at 656, was, of course, lethal injection, exactly the method attacked in *Baze* v. *Rees*. See *Baze*, 553 U. S., at 104 (Thomas, J., concurring in the judgment).[7]

In the abstract, it is easy to say that states should move to methods inflicting less pain or creating less risk of severe pain as improved methods become available. As the history noted above indicates, they have generally done that. Imposing such a requirement as a constitutional mandate, however, would severely distort the democratic process of deciding whether a state will have capital punishment.

Enacting or repealing a statute is not easy, by design. Most states follow the federal model where enacting a statute requires majorities in both houses of the state legislature plus concurrence of the governor or

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7. Later challenges to the gas chamber after the lethal injection alternative was made available were rejected in *Gomez* v. *Fierro*, 519 U. S. 918 (1996) (grant, vacate, remand) and *Stewart* v. *LaGrand*, 526 U. S. 115, 119 (1999) (waiver).

a two-thirds majority in both houses to override a veto. See National Conference of State Legislatures, Inside the Legislative Process 6-33 (1998).[8] Once the lawmaking authorities have come to this level of agreement, the decision should remain in place unless and until there is the same level of agreement to change it. Repealing a statute therefore requires the same process as enactment. In the legislative process, blocking legislation is far easier than repealing legislation. If a state is constitutionally required to enact new legislation to maintain an existing law, then a determined minority can effectively repeal a law merely by blocking the maintenance bill in one house or convincing the governor to veto it.

New York provides an example. Murder in the first degree is a capital offense by statute in New York and has been throughout the modern era, see N. Y. Crim. Proc. L. § 400.27, but opponents of the death penalty have been able to nullify the law most of that time by blocking the legislation to fix real or fabricated problems with it. See *People* v. *Davis*, 43 N. Y. 2d 17, 32, 371 N. E. 2d 456, 463 (1977) (1974 mandatory law); *People* v. *Taylor*, 9 N. Y. 3d 129, 156-157, 878 N. E. 2d 969, 984-985 (2007) (Smith, J, concurring) (precedent striking down 1995 law was wrongly decided, but not overruled as a matter of *stare decisis*). Such repeal-by-deadlock would become a frequent occurrence if states were required to regularly enact new execution methods from time to time, allowing opponents to effectively repeal laws that they are unable to actually repeal through the regular democratic process. And that is precisely the idea. Cf. *Baze*, 553 U. S., at 71 (Alito, J., concurring) (warning of *de facto* ban by litigation

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8. http://www.ncsl.org/documents/legismgt/ILP/98Tab6Pt3.pdf.

gridlock); *id.*, at 105 (Thomas, J., concurring in the judgment).

Making the "best practices" a constitutional mandate could actually inhibit the adoption of improvements. If opponents of the death penalty believe that they have a chance of getting a state's law struck down by blocking a new, better, more humane method, they might well oppose it for that reason. Indeed, the present case arises precisely because of such a cynical blockage, though it occurs in the commercial realm rather than the legislative one. Oklahoma is forced to use the suboptimum drug because and only because opponents of the death penalty have blocked the optimum one.

C. Nelson and Hill.

Yet alternatives are relevant under *Baze*. The case Petitioners cite as rejecting a need to show an alternative does not support their argument.

The switch to lethal injection seemed to eliminate method-of-execution litigation for about a decade, but then it was back as the formerly preferred alternative came under attack. One preliminary question that needed to be resolved was whether a habeas corpus petition or a civil rights suit under 42 U. S. C. § 1983 was the correct procedure. This procedural question, not the substantive Eighth Amendment question, was at issue in *Nelson* v. *Campbell*, 541 U. S. 637, 639 (2004) and *Hill* v. *McDonough*, 547 U. S. 573, 585 (2006).

In *Nelson*, an inmate with compromised veins challenged the state's plan to use a "cut down" procedure as a last resort to gain venous access. 541 U. S., at 641-642. The Court held that this particular claim, not "method-of-execution claims generally," could proceed

as a § 1983 action. *Id.*, at 644. The Court emphasized that "the gravamen of petitioner's entire claim is that use of the cut-down would be *gratuitous*." *Id.*, at 645 (emphasis in original). If on remand the challenged procedure turned out to actually be necessary to execute the judgment, the holding that the case could proceed under § 1983 rather than habeas would not apply. *Id.*, at 646.

Significantly, the *Nelson* Court noted that a stay of execution, initially requested by Nelson, undermined his position on the applicability of § 1983. Relief that goes beyond prohibiting the specific practice complained of to prevent the execution altogether raises doubt as to whether the case can proceed as a civil rights action and potentially conflicts with the requirement of the Prison Litigation Reform Act that relief extend no further than necessary. *Id.*, at 648. See Part II, *infra*, at 20-22.

Hill v. *McDonough*, which Petitioners rely on heavily, see Brief for Petitioners 48-49, was also a habeas versus § 1983 case. See 547 U. S., at 576. Essential to the holding that the case could proceed under § 1983 was the fact that "respondents do not contend, at least to this point in the litigation, that granting Hill's injunction would leave the State without any other *practicable*, legal method of executing Hill by lethal injection." *Id.*, at 580 (emphasis added).

The *Hill* Court did decline the suggestion of *amicus* United States to create a special pleading requirement for all method-of-execution challenges under § 1983 that "the prisoner [must] identif[y] an alternative, authorized method of execution." *Id.*, at 582. However, Petitioners place more weight on this holding than it can bear. The Court's reluctance to impose a special pleading requirement through case law when such requirements are more properly established by rule, see *ibid.*, does not mean that the fact at issue is irrelevant

to either the substance of claim or the proper form of action. Quite the contrary, *Hill* says the existence of an alternative is quite relevant to the latter point. "If the relief sought would foreclose execution, recharacterizing a complaint as an action for habeas corpus might be proper." 547 U. S., at 582.[9] Of course "*Baze* did not overrule" *Hill*. See Brief for Petitioners 28, 51. There was no reason to do so. The cases addressed different questions. *Hill* addressed jurisdiction to proceed under § 1983 rather than habeas and whether special pleading requirements apply, while *Baze* addressed the merits of the underlying Eighth Amendment claim, an issue *Hill* expressly disclaimed any opinion on. See 547 U. S., at 585.

Petitioners rely on *Jones* v. *Bock*, 549 U. S. 199, 213 (2007), for their expansive interpretation of *Hill*, Brief for Petitioners 28, but in context *Jones*'s citation of *Hill* cuts the other way. The question the Court was considering there is succinctly stated at the beginning of Part II of the opinion.

> "There is no question that exhaustion is mandatory under the PLRA and that unexhausted claims cannot be brought in court. [Citation.] What is less clear is whether it falls to the prisoner to plead and demonstrate exhaustion in the complaint, or to the defendant to raise lack of exhaustion as an affirmative defense." *Id.*, at 211.

This is all about *who* has to raise in the pleadings a fact of unquestioned importance to the decision. That is the

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9. Recharacterization as habeas would invoke limitations as to exhaustion if the inmate had not presented his claims to the state courts and deference if he had, see 28 U. S. C. §§ 2254(b), (d), such that it would be unlikely he could prevail in federal court. The successive petition limitation might also bar some petitions. See *Hill*, *supra*, at 576.

context in which *Jones* cites *Hill*, right after it says that discrimination plaintiffs do not have to "specifically allege the elements of a prima facie case of discrimination." *Id.*, at 213. They still must establish the elements to prevail, obviously. A pleading requirement is not a rule of substantive law.

Nothing in *Nelson* or *Hill*, therefore, negates the relevance of the existence of "other legal, practicable method[s]" as a factor in the substance of an Eighth Amendment challenge to a method of execution. The gas chamber cases did not address that issue on the merits. See *supra*, at 9, and n. 7. *Baze* v. *Rees* was therefore the first case in this Court in the modern era to squarely present the substantive Eighth Amendment question.

D. Baze, Risk, and Alternatives.

In *Baze*, unlike previous method of execution challenges, the method was concededly painless as designed. See *Baze*, 553 U. S., at 41 (plurality opinion). Under *Wilkerson* and *Kemmler*, that would be the end of the case, as only intentionally torturous methods violate the Eighth Amendment. Justice Thomas, joined by Justice Scalia, concurring in judgment, would so hold. See *id.*, at 94, 102. However, the plurality opinion allowed for the possibility of an Eighth Amendment violation based on a risk of unintentionally inflicted pain.

"When there is no majority opinion, the narrower holding controls." *Panetti* v. *Quarterman*, 551 U. S. 930, 949 (2007) (citing *Marks* v. *United States*, 430 U. S. 188, 193 (1977)). In some cases this rule is "more easily stated than applied," *Nichols* v. *United States*, 511 U. S. 738, 745 (1994), but in this case there appears to be general agreement that the plurality opinion is

controlling in *Baze*. See J. A. 123-124, n. 6 (Court of Appeals opinion, collecting cases).[10]

The *Baze* plurality standard requires "a demonstrated risk of severe pain" that is "substantial when compared to the known and available alternatives." 553 U. S., at 61; see also *id.*, at 52. *Amicus* submits that severity, degree of risk, and alternatives are conjunctive requirements that apply to all claims of unintended, or at least unknowing, pain in execution.

The first question is what kinds of claims this three-part standard applies to. That is, what are the "grounds such as those asserted here," referred to by the *Baze* plurality. See 553 U. S., at 61. After reviewing the *Wilkerson* and *Kemmler* decisions and their formulation of the intentional infliction of pain "superadded" to death as additional punishment, see *id.*, at 48-49, the plurality turned to cases regarding civil liability for injuries to prisoners for recognition of an additional Eighth Amendment prohibition against "subjecting individuals to a risk of future harm." See *id.*, at 49-50 (citing *Helling* v. *McKinney*, 509 U. S. 25 (1993) and *Farmer* v. *Brennan*, 511 U. S. 825 (1994)). In this line of cases, we see that different rules apply based on the mental state of the prison officials. If injury is caused "maliciously and sadistically for the very purpose of causing harm," then liability can be imposed even if the use of force occurs while putting down a prison disturbance, and there is no threshold requirement of a serious injury. See *Hudson* v. *McMillian*, 503 U. S. 1, 6-7 (1992) (internal quotation marks omitted). In contrast, a claim of "deliberate indifference" to a risk requires a "substantial risk of serious harm," *Farmer* v. *Brennan*, 511 U. S. 825, 834

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10. All further *Baze* citations are to the plurality opinion unless otherwise indicated.

(1994), and such claims are not available at all for uses of force that "are typically made in haste, under pressure, and without the luxury of a second chance." *Id.*, at 835 (citations and internal quotation marks omitted). *Farmer* refers to the *mens rea* categories of the criminal law, defining "deliberate indifference" as less than "purpose or knowledge," *id.*, at 836, and equivalent to "subjective recklessness as used in the criminal law." *Id.*, at 839-840.

The *Baze* plurality's adoption of the *Helling/Farmer* standards suggests where to draw the line on its application. If a method is adopted with the *purpose* of causing pain, that is an Eighth Amendment violation under *Wilkerson* and *Kemmler*. The existence of alternatives is irrelevant for such a claim. See *Baze*, 553 U. S., at 102 (Thomas, J., concurring in the judgment) (no "comparative analysis" in *Wilkerson* and *Kemmler*). From *Farmer*'s reference to "purpose or knowledge" together, we can infer that a state's method of execution would similarly be unconstitutional if it were *known* to cause extreme pain without a need to consider the availability of alternatives. See *Warner* v. *Gross*, 135 S. Ct. 824, 826, 190 L. Ed. 2d 903, 906 (2015) (Sotomayor, J., dissenting) ("burned alive"); Brief for Petitioners 47-48. It is when we move from purpose to cause pain or knowledge that a method *will* cause extreme pain into claims of deliberate indifference to a *risk* it will do so that alternatives become important.

The requirement to consider available alternatives also comes from root Eighth Amendment principles. There is no dispute in these cases that the Eighth Amendment only prohibits *unnecessary* pain. See *Baze*, 553 U. S., at 114 (Ginsburg, J., dissenting); *Warner*, 135 S. Ct., at 828, 190 L. Ed. 2d, at 907 (Sotomayor, J., dissenting). Carrying out the well-deserved and thor-

oughly reviewed sentence for a horrific crime is *necessary*. The extreme delays presently (and unnecessarily) being incurred to review cases multiple times in multiple courts, typically on claims having nothing to do with actual guilt, are bad enough. For justice to be further delayed, perhaps by years, for further litigation over method of execution is a travesty. Given the necessity to execute the judgment, a state is not causing unnecessary pain if it endeavors to execute the judgment via a method that does not have a risk of severe pain that is substantially greater than any other method available to it.

The requirement that the pain in question be severe is also worth noting here. The *Baze* plurality quotes *Farmer* referring to a "substantial risk of serious harm" and adopts that standard, 553 U. S., at 52, but in applying the word "harm" in this standard it is important to consider the different contexts of the cases. In *Farmer* and the other cases involving injuries to persons sentenced to incarceration, physical harm was "simply not 'part of the penalty'" to which the inmates were sentenced. See *Farmer*, 511 U. S., at 834. In a method-of-execution case, the ultimate physical harm, death, is the very sentence imposed. Further, from the earliest days of the republic until fairly recently, it was understood that some degree of pain in the execution of the sentence was to be expected though not intended. *Baze* did not need to go into the degree of pain in any detail because the method in question was conceded to be painless if it worked as designed, but the claimed risk was of excruciating pain. See 553 U. S., at 113 (Ginsburg, J., dissenting). In stating that the standard resolves a great many cases, the plurality says the prisoner must show "a demonstrated risk of *severe* pain." *Id.*, at 61 (emphasis added). Thus there is a threshold requirement for severity of pain. *Cf. id.*, at 116 (Ginsburg, J., dissenting). A risk, however large

and however avoidable, of some lesser degree of pain incident to an execution does not establish an Eighth Amendment violation or entitle a prisoner alleging it to a stay.

Do the Petitioners have a *Wilkerson* claim rather than a *Baze* claim? That is, is midazolam so completely incapable of preventing the extreme pain that an unanesthetized person would feel upon the injection of the second and third drugs that such pain is essentially certain, and has this been established so clearly that the Oklahoma officials can be charged with knowledge that this result *will* follow, not merely deliberate indifference to a risk that it *might* follow? The thrust of Part III of their argument, see Brief for Petitioners 46-48, seems to imply something along these lines. If that is the argument, though, it appears to be unsupported by the record in this case.

In their extensive discussion of the testimony regarding the protocol at issue in this case, Petitioners do not point to a single statement in any of their experts' testimony or reports that this protocol would necessarily result in extreme pain. See Brief for Petitioners 9-19. Instead, they hammer over and over on the minimally relevant testimony that midazolam is not considered a sufficient anesthetic for surgery and cannot induce a comalike state. See *id.*, at 12, 13, 16. Producing the degree of pain reduction or complete elimination that doctors want for their patients is not the test. It is not the Eighth Amendment requirement. There is a wide gap, indeed a chasm, between the standard of care for patients in medicine and the minimal requirement that murderers not be tortured. To say that midazolam is not "adequate anesthesia" in a medical context, see *id.*, at 13-14, is not to say that it cannot meet the far lower standard of reducing any

pain experienced in execution to a level that is acceptable for Eighth Amendment purposes.

In addition to the record in this case, the Court has been presented with an *amicus* brief devoted entirely to the properties of midazolam. See Brief for Sixteen Professors of Pharmacology as *Amici Curiae*. This brief similarly fails to address the actual question. It begins with the assumption that a "comalike unconsciousness" like that produced by thiopental is required, see *id.*, at 9, and then proceeds to describe why midazolam cannot provide that. The graph on page 19 indicates that the effects of midazolam reach a plateau a bit short of full anesthesia. That effect may not result in the complete painlessness achievable with barbiturates, but is it sufficient to avoid the extreme pain forbidden by the Eighth Amendment? The brief does not say.

Neither in the District Court, nor as supplemented in the Court of Appeals, nor as further supplemented in this Court does the case for the Petitioners rise to the level of a *Wilkerson* claim. The state is not using a method for the purpose or with the knowledge that it will result in a torturous level of pain. That leaves the *Baze* standard, and again their case fails as already described by the District Court, the Court of Appeals, and the Brief for Respondents. Petitioners must show that there is "a demonstrated risk of severe pain" that is "substantial when compared to the known and available alternatives." Thiopental and pentobarbital are not alternatives available to the State of Oklahoma at present due to a concerted effort by opponents of the death penalty to make them unavailable. The state may constitutionally proceed with a method available to it that is not substantially, demonstrably inferior to other *available* methods.

II. Any relief granted in a federal court should be the least intrusive possible, with injunction of the execution only as a last resort.

In the Prison Litigation Reform Act of 1995 (PLRA), Congress limited the authority of federal courts to grant relief in prison conditions cases, which include actions "with respect to the effects of actions by government officials on the lives of persons confined in prison . . . " 18 U. S. C. § 3626(g)(2). That language is broad enough to include method-of-execution cases. See *Nelson* v. *Campbell*, 541 U. S. 637, 650 (2004) (noting PLRA applies). That Act provides,

> "Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is *narrowly drawn*, extends *no further than necessary* to correct the violation of the Federal right, and is the *least intrusive means* necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief." 18 U. S. C. § 3626(a)(1)(A) (emphasis added).

Preventing the execution of a valid judgment of a state court is a particularly intrusive form of relief. As far back as the Second Congress, there has been a general prohibition of federal court stays of state court proceedings. See Act of Mar. 2, 1793, ch. 22, § 5, 1 Stat. 334-335. That prohibition is now codified as 28 U. S. C. § 2283. Although the civil rights private action statute, 42 U. S. C. § 1983, has been held to be an exception, prudence still requires that federal injunctions interfere

with state criminal justice systems as little as possible. See *Rizzo* v. *Goode*, 423 U. S. 362, 379-380 (1976).

Congress has further recognized that victims of crime have a "right to proceedings free from unreasonable delay." 18 U. S. C. §3771(a)(7). Congress has extended the explicit protection of this right to federal habeas corpus petitions by state prisoners, *id.*, subd. (b)(2)(A), which has been the primary means by which federal courts have violated the rights of victims of state crimes. Though the act may not directly apply to federal civil actions, the principles that motivated Congress to enact it should be considered in the same way that *Rizzo* noted with the Anti-Injunction Act. By the time capital cases complete state court review and federal habeas, the families of the victims have typically waited far too long for justice already. To further delay justice with a federal civil action, possibly for years, would require the most compelling justification.

Finally, there is reason to doubt whether a federal court in a § 1983 action even has jurisdiction to issue an injunction that, in practice, amounts to an indefinite stay of execution. If the plaintiff seeks an injunction that prohibits the use of the only method that state law allows, that "may amount to a challenge to the fact of the sentence itself," and thus require a habeas corpus petition rather than a § 1983 action. See *Nelson* v. *Campbell*, 541 U. S., at 644; *Hill* v. *McDonough*, 547 U. S., at 582; see also *supra*, at 13, n. 9.

As explained in Part I, *supra*, the existence of an available alternative is an important factor in determining whether a given protocol violates the Eighth Amendment so that any relief at all is warranted. If a court finds that there is a violation and relief is warranted, it may need to choose between an order that says "do not use method X" or one that says "use method Y instead of method X." In most cases, *amicus*

CJLF submits, the latter will be less intrusive, more respectful of federalism, more respectful of the rights of the victims, and more clearly within the court's § 1983 jurisdiction.

An order that simply bars one method may require the state to start over and formally adopt another method. Condemned inmates may then start the litigation process over, file new challenges to the new method, and demand new temporary restraining orders and preliminary injunctions while they litigate that new method. Victims of crime who have already waited far too long may have to wait years longer. Where the relief granted directs that the execution of the state judgment proceed but by a different method, the jurisdictional problem identified in *Nelson* and *Hill* does not arise. Without such an alternative, the court issues an order that it may not have jurisdiction to issue.

For all of these reasons, a federal court hearing a method-of-execution challenge in a § 1983 action should not only require the plaintiff to identify an available alternative method, but the relief granted, if any, should direct the use of that method rather than simply forbid use of the state's original method.

III. The United States must not allow its justice to be obstructed by an antidemocratic and largely foreign conspiracy.

Each Fourth of July, we celebrate the day that the Second Continental Congress declared that the United States of America were ready "to assume among the Powers of the Earth the separate and equal Station to which the Laws of Nature and of Nature's God entitle them . . ." See Declaration of Independence, para. 1 (1776). While acknowledging the need for "a decent

Respect to the Opinions of Mankind," *ibid.*, the whole point was not to be governed by others but rather for the *people* of the country "to institute new Government, laying its Foundations on such Principles . . . as *to them* shall seem most likely to effect their Safety and Happiness." *Id.*, para. 2 (emphasis added).

The consensus of the people of the United States, the law of its federal government, and the law of an overwhelming majority of its states is that death is the appropriate punishment for the worst murders. See Part IV, *infra*. The United States must not allow the execution of the sentences that most of its people believe to be just to be blocked by the actions of foreign governments, foreign corporations, or a minority within the United States that has failed to achieve its goals by democratic means and therefore resorts to undemocratic ones. That would be the result if a rule of law is created that requires use of only the optimum methods of execution when those optimum methods can be rendered unavailable by agreements in restraint of trade, particularly those erected under foreign pressure.

While the United States should refrain from actions that violate the treaties it has duly ratified, other countries should respect the right of the United States to make its own choices within the bounds allowed by those same treaties. The relevant treaty to which the United States and the countries of Europe are parties is the International Covenant on Civil and Political Rights (ICCPR), Dec. 19, 1966, 999 U. N. T. S. 171 (entered into force Mar. 23, 1976). Article 6 of that agreement permits capital punishment under certain conditions, all of which the United States complies with. Although the United States originally made a reservation regarding Article 6(5), see *Roper* v. *Simmons*, 543 U. S. 551, 567 (2005), that reservation was rendered moot by *Roper*.

Continued use of capital punishment by the United States in compliance with all the conditions of the ICCPR is therefore no legitimate concern of European governments. They can let their own murderers off with absurdly light punishments if they choose. See, *e.g.*, Anders Behring Breivik: Norway Court Finds Him Sane, BBC News (Aug. 24, 2012) (21 years for murdering 77 people, 3¼ months per life).[11] They can make further agreements among themselves, and they can bludgeon other countries into abolition of capital punishment as the price for the economic advantages of joining the European Union. See Gibson & Lain, Death Penalty Drugs and the International Moral Marketplace 22 (rev. Feb. 26, 2015), Georgetown L. J., vol. 103 (forthcoming).[12] None of this amounts to a license for meddling in America's contrary choice.

> "The use of the death penalty in the United States is a decision of democratically elected governments at the federal and individual State levels and is not prohibited by international law. Capital punishment does not violate any OSCE commitments. The people of the United States, acting through their freely elected representatives, have chosen, in most States, not to abolish the death penalty." United States Mission to the OSCE, Response to the European Union's Statement on the Death Penalty (May 14, 2009). [13]

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11. http://www.bbc.com/news/world-europe-19365616.

12. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2524124. *Amicus* CJLF cites this paper only for its historical information. *Amicus* does not endorse the views of the authors, who seem to think that European government meddling in American criminal justice policy is a good thing.

13. http://www.osce.org/pc/37216?download=true.

Yet they meddle nonetheless, and their meddling led to Oklahoma's adoption of midazolam and to the present case.

There is no doubt that barbiturates are the preferred agents if the goal is to induce a painless death. The American Veterinary Medical Association endorses injectable barbiturates as the preferred method of euthanasia for primates. See American Veterinary Medical Association, Guidelines for Euthanasia of Animals 50, 99 (2013 ed.).[14] Thiopental was the primary agent in the physician-assisted euthanasia method developed in the Netherlands. See *Baze* v. *Rees*, 553 U. S. 35, 58 (2008) (plurality opinion of Roberts, C.J.). Oklahoma would use them if they were available. See J. A. 79.

The history of the supply restriction, including the underappreciated role of European governments, is traced in a forthcoming article in the Georgetown Law Journal, Gibson & Lain, *supra*. "At first blush, the drug shortage appears to be the result of pharmaceutical industry norms; companies that make drugs for healing have little interest in being merchants of death. But closer inspection reveals that European governments are the true instigators of the shortage." *Id.*, Abstract.

Sodium thiopental was the drug used in the first step of the three-drug protocol in most if not all states with capital punishment at the time of *Baze* v. *Rees*. See 553 U. S., at 44. For reasons unrelated to capital punishment, the sole American manufacturer of thiopental, Hospira, decided to move its production to a facility in Italy. The Italian subsidiary of Hospira

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14. The AVMA specifies "nonhuman primates" in accordance with their scope of practice. See *id.*, § I2.3, at 6.

initially took the position that what was done with its drugs was not its concern. See Hands Off Cain and Reprieve, Lethal Trade: How an Abolitionist Country is Collaborating in Putting People to Death in the United States, Hands Off Cain (Dec. 2, 2010).[15] The Italian government then threatened the company with denial of a license and with legal liability for itself and its employees, and Hospira got out of the thiopental market altogether. Gibson & Lain, *supra*, at 25-27. Other European governments then moved to cut off other sources. *Id.*, at 27. "European governments were driving this train; the pharmaceutical industry merely climbed on board once it became clear that state actors were serious about using the market to fight capital punishment." *Id.*, at 28.

States then turned to pentobarbital. This is the drug of choice for animal euthanasia. See R. Rhoades, The Humane Society of the United States Euthanasia Training Manual 3-4 (2002). This drug was manufactured in the United States by a Danish company, H. Lundbeck A/S. Lundbeck restricted its distribution to buyers who agreed not to redistribute the drug for capital punishment. See Gibson & Lain, *supra*, at 12-13. Again, however, it did so only after being pressured by European governments. *Id.*, at 29.[16] When Lundbeck sold the rights to the drug to an American company, Akorn, Inc., the sale agreement required continuation of the restrictive distribution system. See Lundbeck Divests Several Products in the US As Part of

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15. http://www.handsoffcain.info/chisiamo/index.php?idtema=13316650.

16. Whether this amounts to growing a backbone, see *ibid.*, or lacking one is debatable.

Long-Term Business Strategy, H. Lundbeck A/S, Press Release (Dec. 22, 2011).[17]

The stratagem of cutting off the supply of the optimum drugs for lethal injection has, so far, not succeeded in producing a major reduction in the number of executions in the United States. States have gone to other drugs or found other sources of supply. The paradoxical result that a campaign by death penalty opponents may have resulted in unneeded pain being inflicted on the inmates they were supposedly trying to help has not gone unnoticed. See Deng & Lithwick, Liberal Guilt: In the Push to Abolish the Capital Punishment, Opponents of the Death Penalty Have Made It Less Safe, Slate (May 9, 2014).[18] Participants in this conspiracy are no doubt hoping that a rule of law will emerge from this case that enhances their ability to meddle in the American criminal justice system and frustrate the will of the people as expressed in democratically enacted laws. If this Court cuts off all methods that are less than optimum and if market manipulation or coercion can cut off the optimum methods, then the stratagem may yet succeed.

For the sake of American sovereignty and democracy, it is important that this stratagem fail. The people of the United States must retain the ability to decide how best to punish the perpetrators of the most heinous crimes committed within our country. We must not allow ourselves to be dictated to by European governments or by a handful of corporations. So long

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17. http://investor.lundbeck.com/releasedetail.cfm?ReleaseID=635094.

18. http://www.slate.com/articles/news_and_politics/jurisprudence/2014/05/death_penalty_in_america_how_the_push_to_abolish_capital_punishment_has.html.

as the less-than-optimum methods are not torturous, they must remain available unless and until the optimum methods become available again.

IV. The national consensus is that capital punishment serves an important function and needs to be enforced.

A group calling itself the National Consensus Project (NCP) has filed an *amicus curiae* brief contending that a national consensus supports a decision in favor of the murderers in this case. See generally Brief of the National Consensus Project, *et al.*, as *Amici Curiae* (NCP Brief). Actually, the one clear national consensus in this area is that death is the appropriate punishment for the worst murderers, and the sentences need to be carried out.

After this Court declared unconstitutional the then-existing death penalty statutes in *Furman* v. *Georgia*, 408 U. S. 238 (1972), the reaction of the American people through the democratic process was swift and overwhelming.

> "The most marked indication of society's endorsement of the death penalty for murder is the legislative response to *Furman*. The legislatures of at least 35 States have enacted new statutes that provide for the death penalty for at least some crimes that result in the death of another person. And the Congress of the United States, in 1974, enacted a statute providing the death penalty for aircraft piracy that results in death." *Gregg* v. *Georgia*, 428 U. S. 153, 179-180 (1976) (lead opinion) (footnotes omitted).

That "marked indication" remains essentially unchanged today. Over two-thirds of the states and the

federal government have current death penalty laws, outstanding death sentences, or both. U. S. Department of Justice, Bureau of Justice Statistics, Capital Punishment, 2013—Statistical Tables 1 (2014). Although a few state legislatures have decided not to seek new death sentences for future crimes, these statutes do not represent a rejection of death as an appropriate punishment, as demonstrated by the fact that all but one of the recent repeal statutes have provided for the continuation of existing sentences. See *id.*, at 1, n. * Instead, recent repeal efforts have been largely based on practical arguments invoking the extreme delays and high costs.[19] For example, in a 2012 initiative to repeal the death penalty in California, the proponents mentioned only the risk of executing an innocent person as an argument against capital punishment as such. The rest of the argument was devoted entirely to matters of cost. Not a single word in the argument even suggests that death is an unjust punishment for a person guilty of the worst kind of murder. Cal. Secretary of State, Official Voter Information Guide, California General Election 40 (2012) (argument in favor of Proposition

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19. Reasons for the extreme delays and costs include the bloating of the constitutional requirement of mitigating evidence to include vast amounts of irrelevant or minimally relevant information, see *Graham* v. *Collins*, 506 U. S. 461, 500 (1993) (Thomas, J., concurring), massive resistance of some federal courts to the Chapter 153 reforms of the Antiterrorism and Effective Death Penalty Act of 1996, see *Lopez* v. *Smith*, 574 U. S. __, 135 S. Ct. 1, 2, 190 L. Ed. 2d 1, 2 (2014) (*per curiam*) ("time and again"), and the obstruction of the Chapter 154 reforms. See *Habeas Corpus Resource Center* v. *Dept. of Justice*, No. 4:13-cv-04517-CW, 2014 U. S. Dist. LEXIS 109532 (ND Cal., Aug. 7, 2014) (appeal pending) (enjoining implementing regulations); cf. 28 U. S. C. § 2265(c)(2) (exclusive jurisdiction in the D.C. Circuit).

34).[20] Even the most intractable opponents of the death penalty know that they have no chance of convincing the American people on the basic moral correctness of capital punishment for the worst murderers.[21]

NCP purports to show a "consensus" against the use of midazolam by adding up jurisdictions that have no death penalty (including New York, where the democratically enacted statute is still on the books, blocked by a dubious judicial decision, see *supra*, at 10), NCP Brief 11, jurisdictions where execution has been blocked by the unilateral act of a governor misusing the reprieve power, *id.*, at 11-13, states that have not conducted executions because of a combination of having small death row populations and lengthy judicial delays, *id.*, at 13-14,[22] states that have not carried out many executions without reasons given for the rarity, *id.*, at

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20. Despite a massive campaign funding imbalance, the initiative still lost. See Ballotpedia, California 2012 Ballot Propositions, http://ballotpedia.org/California_2012_ballot_propositions (Prop. 34).

21. For what it is worth, properly asked poll questions consistently show strong support for the death penalty. See Scheidegger, Americans' Support for Death Penalty Stable, Crime and Consequences Blog (Oct. 23, 2014), http://www.crimeandconsequences.com/crimblog/2014/10/americans-support-for-death-pe.html, and they have for a long time. Only very badly skewed questions show an even split. See *ibid.*

22. The extreme hostility of the Supreme Court of Kansas to capital punishment says nothing about a consensus of the *people* of that state. Despite its small death row, this Court has found it necessary to take up a disproportionately large number of that court's capital case reversals. See *Kansas* v. *Cheever*, 571 U. S. __, 134 S. Ct. 596, 187 L. Ed. 2d 519 (2013) (unanimously reversed); *Kansas* v. *Marsh*, 548 U. S. 163 (2006) (reversed); *Kansas* v. *Carr* (Jonathan), No. 14-449 (cert. granted); *Kansas* v. *Carr* (Reginald), No. 14-450 (cert. granted); *Kansas* v. *Gleason*, No. 14-452 (cert. granted).

14-15, and states that so far have not needed to resort to midazolam, with one exception. See *id.*, at 15-17.

The last group warrants a closer look. Of the states listed in this group, only Ohio has actually used midazolam and then suspended executions rather than continue using it. NCP Brief 16, n. 21. The protocol in use there was midazolam plus hydromorphone, a different protocol than the one at issue in this case. See *In re Ohio Execution Protocol Litig.*, 994 F. Supp. 2d 906, 912 (SD Ohio 2014). Other states actively carrying out executions have, so far, been able to obtain pentobarbital, but the future is uncertain. See Berman, Texas Finds More Lethal Injection Drugs After All, The Washington Post (Mar. 25, 2015).[23]

The only consensus that NCP's collection establishes is that pentobarbital or thiopental is preferable to midazolam *when the state can get it*. That is not in dispute. Oklahoma agrees. See J. A. 79. NCP has not demonstrated a consensus that halting executions that would otherwise go forward is preferable to using midazolam. There is no such consensus and cannot be because most states have not been faced with that question. In the vast majority of jurisdictions, either executions are halted for reasons having nothing to do with the issue in this case or they are going forward with the drugs that everyone agrees is preferred when available. It is preposterous to assert that a state's nondecision on a question it does not face can be counted in determining a national consensus.

The consensus that counts for the purpose of the Eighth Amendment is the consensus of the *people*. Legislation enacted by state legislatures and direct

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23. http://www.washingtonpost.com/news/post-nation/wp/2015/03/25/texas-finds-more-lethal-injection-drugs-after-all/.

votes by the people are strong indications, see *Gregg* v. *Georgia*, 428 U. S., at 179-181, but actions by other state actors have far less value. The primary, enduring consensus of American society in this area is that death is the appropriate punishment for the worst murders. Execution of these judgments, after the cases have been thoroughly reviewed, should not be halted merely because the preferred method has been blocked by nefarious means so long as an acceptable one remains available.

CONCLUSION

The decision of the Court of Appeals for the Tenth Circuit should be affirmed.

April, 2015

Respectfully submitted,

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In the Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

BRIEF FOR STATE OF FLORIDA AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Table of Authorities ii

Introduction and Statement of Amicus Interest..... 1

Summary of Argument 2

Argument..... 2

I. Florida's Experience Demonstrates That Midazolam Can Be Used in Humane, Constitutional Executions. 2

II. Florida's Experience With Midazolam Is Consistent with Findings of Fact of All Other Courts Weighing Evidence on Petitioners' Claim... 5

III. States Adjust Execution Protocols to Reduce Risk of Harm..... 14

IV. This Court Should Reject Petitioners' Argument That It Should Reweigh Evidence. 15

Conclusion 16

TABLE OF AUTHORITIES

Cases

Anderson v. City of Bessemer City, N.C.,
470 U.S. 564 (1985) 15

Baze v. Rees,
553 U.S. 35 (2008) 1, 9, 13, 16

Chavez v. Fla. SP Warden,
742 F.3d 1267 (11th Cir. 2014) 2, 3, 13

Chavez v. Palmer,
No. 3:14-cv-110-J-39JBT, 2014 WL 5210673 (M.D. Fla. Feb. 10, 2014) 5, 8, 12

Correll v. State,
No. SC15-147 (Fla. Feb. 17, 2015) 4

Davis v. State,
142 So. 3d 867 (Fla. 2014) 6

Florida v. Correll,
135 S. Ct. 1491 (2015) 4

Harbison v. Little,
723 F. Supp. 2d 1032 (M.D. Tenn. 2010) 8

Henry v. State,
134 So. 3d 938 (Fla. 2014) 5

Howell v. State,
133 So. 3d 511 (Fla. 2014) ..... passim

Lightbourne v. McCollum,
969 So. 2d 326 (Fla. 2007) 14

Muhammad v. Crews,
No. 3:13–cv–1587–J–32JBT, 2013 WL 6844489 (M.D. Fla. Dec. 27, 2013) 12

Muhammad v. State,
132 So. 3d 176 (Fla. 2013) ..... passim

Schwab v. State,
995 So. 2d 922 (Fla. 2008) 11

Valle v. Singer,
655 F.3d 1223 (11th Cir. 2011) 11

Zenith Radio Corp. v. Hazeltine Research, Inc.,
395 U.S. 100 (1969) 15

Other Authorities

1 Ronald D. Miller, et al., *Miller's Anesthesia*, (8th Ed. 2015) 10

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Execution List: 1976-present, *available at www.dc.state.fl.us/oth/deathrow/execlist.html* 3, 14

Frank H. Sarnquist, et. al., *A Bioassay of a Water-soluble Benzodiazepine Against Sodium Thiopental*, 52 Anesthesiology 149 (1980) 11

James T. Conner, et al., *RO 21-3981 for Intravenous Surgical Premedication and Induction of Anesthesia*, 57 Anesthesia & Analgesia 1 (1978) 11

Michael E. Crawford, et. al., *A Randomized Comparison Between Midazolam And Thiopental for Elective Cesarean Section Anesthesia*, 68 Anesthesia & Analgesia 229 (1989) 10

Robert K. Stoelting & Simon C. Hillier, *Pharmacology & Physiology in Anesthetic Practice* (4th ed. 2005) 10

Teresa A. Zimmers & David A. Lubarsky, *Physician participation in lethal injection executions*, 20 Current Opinion in Anesthesiology 147 (2007) 9

INTRODUCTION AND STATEMENT OF AMICUS INTEREST

Florida has an interest in ensuring that it may continue to carry out its lawful judgments using the humane (and constitutional) means it has selected. Although this case relates to a specific drug in a specific three-drug lethal injection protocol, Petitioners' arguments—if accepted—would have a much wider impact. They would undermine this Court's holding in *Baze v. Rees*, 553 U.S. 35 (2008), and threaten the ability of Florida and other States to carry out the punishments their citizens have selected.

The record in this case offers no basis to overturn the lower courts' recognition that midazolam is an effective and constitutional component of a lethal injection protocol.[1] Florida has had eleven successful and uneventful executions using midazolam. And along the way, Florida has addressed virtually identical challenges with virtually identical expert testimony, including testimony from many of the same experts who participated in this case. Weighing that testimony,

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[1] Petitioners highlight the Clayton Lockett execution, *see* Pet'rs' Br. 19, which involved a different quantity of midazolam in a different protocol. It is important to distinguish between the drug combination used in an execution protocol and the overall execution protocol itself. *See infra* Part III. As Oklahoma explains, the issues in the Lockett execution arose from execution procedures, not from the selection of midazolam. *See* Resp. Br. 14-16.

state and federal courts have found—without exception—that Florida's use of midazolam does not violate the Eighth Amendment.

Florida concurs in the arguments presented by Alabama and other states as amici, *see* Amicus Br. of Ala., et al.; it submits this brief separately to highlight its extensive experience with executions involving midazolam.

SUMMARY OF ARGUMENT

Florida's history demonstrates that midazolam, when properly administered, reliably and effectively renders an inmate unconscious for execution by lethal injection. This Court should consider the extensive prior litigation on this issue, which repeatedly affirmed the appropriateness, effectiveness, and constitutionality of Florida's use of midazolam. State and federal courts addressing Florida's use of the drug have thoroughly addressed—and unanimously rejected—the arguments Petitioners present here.

ARGUMENT

I. FLORIDA'S EXPERIENCE DEMONSTRATES THAT MIDAZOLAM CAN BE USED IN HUMANE, CONSTITUTIONAL EXECUTIONS.

In September 2013, facing shortages of previous execution drugs, Florida adopted midazolam as the first drug in its three-drug protocol. *See Chavez v. Fla. SP Warden*, 742 F.3d 1267, 1269 (11th Cir.), *cert. denied sub. nom. Chavez v. Palmer*, 134 S. Ct. 1156 (2014). Florida's protocol calls for (1) 500

milligrams of midazolam, followed by doses of (2) vecuronium bromide and (3) potassium chloride, in that order. *Id.* Midazolam serves as an anesthetic; the second drug is a paralytic that stops muscle movement and respiration; the third drug stops the heart. *Id.*

After Florida adopted the change, the Florida Supreme Court ordered an evidentiary hearing regarding "the safety and efficacy of the new drug in the lethal injection procedure." *Muhammad v. State*, 132 So. 3d 176, 188 (Fla. 2013), *cert. denied*, 134 S. Ct. 894 (2014). And after that evidentiary hearing, the trial court rejected the claim that the use of midazolam would produce a substantial risk of serious harm; it upheld the protocol as constitutional. *See id.* The Florida Supreme Court affirmed. *Id* at 197.

Since the adoption of its current protocol, Florida has successfully carried out eleven lethal injection executions.[2] Each of these executions relied on 500 milligrams of midazolam to produce unconsciousness, and not one involved any sign of suffering or of consciousness following a check specifically designed to determine consciousness, *see infra*.[3] Although now interrupted as a result of this

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[2] The Florida Department of Corrections website maintains a list of Florida executions. *See* Execution List: 1976-present, *available at* http://www.dc.state.fl.us/oth/deathrow/execlist.html (last visited April 14, 2015).

[3] Although there were reports of head movements during William Happ's execution, courts concluded that those movements did not support a finding of pain. *See*

case,[4] Florida's record of consistent, successful executions using midazolam undermines any argument that the drug introduces substantial risk of harm.

While Petitioners rely on speculative allegations and discredited expert testimony, the Court can look to Florida's experience. But even without this track record, the pertinent expert evidence demonstrates that when properly administered, midazolam will produce a level of unconsciousness sufficient to yield a humane and constitutional execution.

Chavez, 742 F.3d at 1271 (quoting district court's finding that "Happ's movement (and Muhammad's, if his eye opened) does not necessarily equate to pain or with consciousness"); *Howell v. State*, 133 So. 3d 511, 519-20 (Fla.), *cert. denied*, 134 S. Ct. 1376 (2014) (quoting trial court's discussion of reported minor movement and conclusion that movement does not equate to consciousness); *Muhammad*, 132 So. 3d at 188 (noting that inmate's expert "acknowledged the movement during Happ's execution did not mean that he was actually harmed") (quoting trial court).

[4] Based on the certiorari grant in this case, the Florida Supreme Court stayed Florida's then-pending execution. *Correll v. State*, No. SC15-147 (Fla. Feb. 17, 2015). This Court denied Florida's application for review. *Florida v. Correll*, 135 S. Ct. 1491 (2015).

II. FLORIDA'S EXPERIENCE WITH MIDAZOLAM IS CONSISTENT WITH FINDINGS OF FACT OF ALL OTHER COURTS WEIGHING EVIDENCE ON PETITIONERS' CLAIM.

Despite Florida's history of successful executions using midazolam, Petitioners insist that a scientific consensus finds midazolam incapable of producing the unconsciousness necessary for a constitutional execution. Pet'rs' Br. 26. But there is no scientific consensus to support Petitioners' claims, and the courts that have considered competing expert evidence (including the district court below) have unanimously resolved factual disputes in favor of the states.

Florida's three-drug protocol is one of the most litigated protocols in the country. There have been no fewer than five evidentiary hearings in state and federal courts addressing its appropriateness for use in executions. Courts have routinely rejected allegations like those Petitioners and some amici assert here, and not one court has concluded that Florida's use of midazolam violates the Eighth Amendment.

First, litigation in Florida has conclusively established that midazolam will render an inmate unconscious within minutes, even with dosages much smaller than the 500 milligrams Florida's protocol requires. *See Muhammad*, 132 So. 3d at 193-94 (noting that experts, including an inmate's expert, acknowledged that midazolam will render an inmate unconscious); *Howell*, 133 So. 3d at 518-20 (noting expert testimony that midazolam would

induce unconsciousness within one or two minutes); *Henry v. State*, 134 So. 3d 938, 947-48 (Fla.), *cert. denied*, 134 S. Ct. 1536 (2014) (noting expert testimony that intravenously delivered midazolam will end consciousness within one or two minutes); *Chavez v. Palmer*, No. 3:14-cv-110-J-39JBT, 2014 WL 521067, at *13 (M.D. Fla. Feb. 10, 2014) (finding expert testimony established that "when midazolam is properly administered," individual will be promptly unconscious), *aff'd Chavez*, 742 F.3d at 1267; *Davis v. State*, 142 So. 3d 867, 873 (Fla.), *cert. denied*, 135 S. Ct. 15 (2014) ("Dr. Evans further testified that midazolam will render an individual unconscious within the span of time necessary to count down from ten to one, and would effectively place an individual in a coma within '5 to 10 minutes.' Dr. Zivot [testifying for the inmate] similarly testified that fifty milligrams of midazolam, which is ten times less than the dose administered under Florida's lethal injection protocol, would render an individual unconscious within 'a matter of a few minutes.'") (quoting circuit court order).

Petitioners in fact acknowledge that midazolam can produce unconsciousness,[5] Pet'rs' Br. 13, but

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[5] In an amicus brief ostensibly supporting neither side, a group of pharmacologists assert that "[m]idazolam cannot induce unconsciousness at any dose." Amicus Br. of Sixteen Professors of Pharmacology in Support of Neither Party at 9. This statement, which has not been subject to cross-examination or courtroom fact-finding, is contrary to a consensus among all professionals who have testified in Florida (including inmates' experts). These

they argue that a consensus finds midazolam will not produce unconsciousness deep or persistent enough for use in executions. More specifically, they argue that midazolam is inappropriate for use as an anesthetic in otherwise painful surgeries, so it cannot suffice as an anesthetic for executions. *Id.* at 32. And they argue that any unconsciousness produced could be threatened by the introduction of noxious stimuli—in this case the drugs injected after midazolam. *Id.* But Petitioners' assertions of consensus cannot square with the evidence in cases that considered the issue.

Midazolam is, in fact, used as an anesthetic for painful procedures. Mark Dershwitz—a medical doctor, practicing anesthesiologist, professor of anesthesiology at the University of Massachusetts Medical School, and Ph.D. in pharmacology—testified in Florida that he "has used midazolam as 'the first and primary drug to induce anesthesia' in neurosurgeries during a drug shortage." *Howell*, 133 So. 3d at 522. Although Dr. Dershwitz's experience involved a 50 milligram dose (one tenth the amount at issue here), he testified "based on his direct experience, where a 50 mg dose prevented his patients from perceiving the noxious stimuli

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experts agree that even in much smaller doses than utilized in Florida's and Oklahoma's protocols, midazolam does indeed induce unconsciousness within minutes. *See supra* at 5-6; *see also Howell*, 133 So. 3d at 519; *Muhammad*, 132 So. 3d at 193-94; *Davis*, 142 So. 3d at 873. And Florida's experience has shown that the inmate is quickly rendered unconscious after the administration of midazolam.

associated with neurosurgery, that it was clear a 500 mg dose would prevent the recipient from being 'able to perceive any noxious stimuli whatsoever.'" *Id.* (quoting trial court).

Dr. Dershwitz's testimony is consistent with testimony of Mark Heath, a board certified anesthesiologist at the New York Presbyterian Hospital at Columbia University. Testifying on behalf of an inmate, Dr. Heath, too, acknowledged the efficacy of midazolam in producing full unconsciousness, even at doses far lower than in Florida's protocol. "Dr. Heath testified that midazolam hydrochloride is an FDA-approved drug in the class of drugs called 'benzodiazepine.' He testified that it is used in the operating room as both a pre-anesthetic and an anesthetic to cause sedation and reduce anxiety, and 'in very high doses will completely ablate consciousness.'" *Muhammad*, 132 So. 3d at 193. While Dr. Heath used small amounts, "such as one milligram" to reduce patient anxiety, he testified that in his experience, a larger dose of 10 or 15 milligrams "will reliably produce a much deeper level of unconsciousness." *Id.* (quoting testimony). Most importantly, Dr. Heath testified that when successfully delivered, midazolam "will have full efficacy as an anesthetic." *Id.* He also opined that "the dosage of midazolam hydrochloride called for in the protocol, 500 milligrams, is a much larger dose than that needed to produce unconsciousness and in that amount would, with certainty, produce death." *Id.* at 194.

Facing all of this, Petitioners rely on the testimony of Dr. David Lubarsky, who said that

midazolam cannot produce sufficient unconsciousness. JA 231; *see also* Pet'rs' Br. 13. But Dr. Lubarsky's testimony about midazolam has been repeatedly rejected, *see, e.g.*, *Chavez v. Palmer*, 2014 WL 521067, at *11 (rejecting Dr. Lubarsky's testimony after making detailed credibility findings); *id.* ("[T]aken as a whole, Dr. Lubarsky's testimony is essentially speculative and insufficient to meet Plaintiff's burden.") (note omitted); *Howell*, 133 So. 3d at 520-22; *cf. Harbison v. Little*, 723 F. Supp. 2d 1032, 1042-44 (M.D. Tenn. 2010) (rejecting challenge to effectiveness of sodium thiopental that included Dr. Lubarsky's testimony), and regardless, his lone opinion could not establish a consensus.[6]

Petitioners also cite a 1985 article, Pet'rs' Br. 13, but that cannot establish any consensus either. Moreover, the cited article does nothing to suggest

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[6] Dr. Lubarsky's opposition to the death penalty is well known; he co-authored an article advocating that physicians work to abolish "lethal injection and all other state sponsored killing." Teresa A. Zimmers & David A. Lubarsky, *Physician participation in lethal injection executions*, 20 Current Opinion in Anesthesiology 147 (2007). He also co-authored a study concluding that a number of executions proceeded with inadequate anesthesia. *See* David A. Lubarsky, et al., *Inadequate Anaesthesia in Lethal Injection for Execution*, 365 Lancet 1412 (2005). As the plurality noted in *Baze*, this study was subject to peer-response criticism in the same journal for its methodology. *See Baze*, 553 U.S. at 51 n.2 (plurality op.) (citing Jonathan I. Groner, *Inadequate Anaesthesia in Lethal Injection for Execution*, 366 Lancet 1073 (2005)).

that in the amounts specified in the Florida and Oklahoma protocols (500 milligrams), midazolam would be ineffective in rendering an inmate unconscious before administration of the second and third drugs. In fact, this article indicates that midazolam, while relatively new at the time of the article's publication, was effective at both the induction and maintenance of anesthesia in much smaller doses than 500 milligrams. The authors concluded that the drug was quickly absorbed and well tolerated, and that its effects are dose related.[7] They then concluded that "[t]here are many uses for midazolam in the perioperative period including premedication, *anesthesia induction and maintenance*, and sedation for diagnostic and therapeutic procedures." J.G. Reaves, et al., *Midazolam: Pharmacology and Uses*, 62 Anesthesiology 310, 320 (1985) (emphasis added); *see also* 1 Ronald D. Miller, et al., *Miller's Anesthesia*, 842 (8th Ed. 2015) ("Midazolam is the benzodiazepine of choice for induction of anesthesia."); *see also supra* at 7-8.

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[7] Notably, another source Petitioners cited (for a different proposition), *Pharmacology & Physiology in Anesthetic Practice* (Pet'rs' Br. 14-16), also recognizes that midazolam can be used to induce anesthesia in a fraction of the dose provided for in the Oklahoma and Florida protocols (.1 to .2mg/kg by IV, or 9-18 mg for a 90kg person). Robert K. Stoelting & Simon C. Hillier, *Pharmacology & Physiology in Anesthetic Practice* 146 (4th ed. 2005). This same authority also recognizes that "[p]atients maintained at higher plasma concentrations of midazolam take longer to awaken than patients maintained at lower plasma concentrations." *Id.* at 147.

Contrary to Petitioners' assertions about scientific consensus, ample authority from multiple evidentiary hearings and published research support midazolam's use as an anesthetic.[8]

Petitioners also contend that the final drug, potassium chloride, could reverse the unconsciousness, waking the inmate who—because of the paralytic—would be unable to demonstrate outward signs of pain. However, the second and

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[8] Other published research has also shown that midazolam compares favorably in its effect to thiopental for induction of anesthesia. *See, e.g.*, Michael E. Crawford, et. al., *A Randomized Comparison Between Midazolam And Thiopental for Elective Cesarean Section Anesthesia*, 68 Anesthesia & Analgesia 229, 229, 232 (1989) (noting that "[m]any studies have established [midazolam's] suitability for induction of anesthesia" and concluding that "midazolam is a suitable alternative to thiopental for induction and maintenance of anesthesia for elective cesarean section"); Frank H. Sarnquist, et. al., *A Bioassay of a Water-soluble Benzodiazepine Against Sodium Thiopental*, 52 Anesthesiology 149, 152 (1980) ("[T]he pharmacologic profile described above makes midazolam maleate a suitable alternative to thiopental for the induction of anesthesia. Midazolam maleate is about 20 times as potent as thiopental for the induction of anesthesia "); James T. Conner, et al., *RO 21-3981 for Intravenous Surgical Premedication and Induction of Anesthesia*, 57 Anesthesia & Analgesia 1, 5 (1978) (concluding that RO 21-3981 (midazolam) "may be more advantageous" than thiopental for induction of anesthesia in certain patients and for others, "does not offer an obvious advantage over thiopental but may well be an effective alternative").

third drugs are administered only after the inmate has been determined to be unconscious. *See* Resp. Br. 17, 32-33; *see also Valle v. Singer*, 655 F.3d 1223, 1233 (11th Cir. 2011) (noting that under Florida's protocol, a consciousness check is required and "the execution cannot proceed until the individual is rendered unconscious"); *Schwab v. State*, 995 So. 2d 922, 930 (Fla. 2008) (detailing the steps of the consciousness check).

Responding to the same concerns Petitioners raise on this point, the Florida Supreme Court addressed Florida's consciousness check explicitly, noting the state's supplementing the eyeball tap and shout with "an additional test to ensure unconsciousness, where the person undertaking the consciousness check added a painful pinch test of the trapezius muscle." *Howell*, 133 So. 3d at 522. This test is the same test physicians have used to test patient consciousness. "In fact, Dr. Lubarsky recognized that before current technology provided other means of testing for unconsciousness, he would similarly use a clamp to pinch a patient's skin to determine whether the patient was able to feel pain." *Id.* Another expert "likewise testified that he would use a painful pinch as the noxious stimuli to ensure that a person was unconscious prior to surgery." *Id.* (citing Dr. Dershwitz's testimony).

The Florida Supreme Court is not the only court to reject claims that midazolam will not sufficiently render inmates unconscious and insensate before the administration of the last two drugs or that the consciousness check is insufficient. *See Muhammad v. Crews*, No. 3:13–cv–1587–J–32JBT, 2013 WL

6844489, at *8 (M.D. Fla. Dec. 27, 2013) (noting that if consciousness check is done correctly after administration of midazolam hydrochloride there is no substantial risk of harm), *aff'd sub nom. Muhammad v. Sec'y, Fla. Dep't of Corrections*, 739 F.3d 683 (11th Cir.) *cert denied sub nom. Muhammad v. Crews*, 134 S. Ct. 894 (2014); *Chavez v. Palmer*, 2014 WL 521067, at *13 (finding expert testimony established that "in the massive dose required by the Florida protocol, [midazolam] will render the individual insensate to noxious stimuli by placing the individual in an anesthetic state, unable to discern pain"). Most importantly, no Florida inmate has failed the tiered consciousness check or required any additional midazolam injections beyond the initial doses.

Finally, Petitioners assert that the possibility of paradoxical reactions make midazolam an inappropriate choice, implying that paradoxical reactions may occur after the inmate is first unconscious. Pet'rs' Br. 14. But the fact-findings rejecting this theory are consistent with the lack of any reported instances of paradoxical reactions (most often manifested by overt consciousness and agitation) in any of the eleven Florida executions using midazolam. *See also Chavez*, 742 F.3d at 1271 ("Dr. Evans testified during the evidentiary hearing that the incidence of paradoxical reactions in normal therapeutic settings was 'less than 1 percent,' and that a massive dose of midazolam would avoid any potential paradoxical reactions and directly render a person unconscious. The district court credited all of that testimony and discredited Dr. Lubarsky's contrary testimony.").

The likelihood that a paradoxical reaction would occur (and none have in any Florida execution), that the inmate would remain conscious, and that the inmate would still pass the graded consciousness check is so remote that it cannot meet the *Baze* standard.

III. States Adjust Execution Protocols to Reduce Risk of Harm.

Experience from Florida demonstrates that midazolam is effective when properly administered as the first drug in a three-drug protocol, similar to the protocol this Court approved in *Baze*. When there are problems with the administration of the drugs, it should not undermine confidence in the selection of the drug itself, and states can be trusted to quickly assess and reevaluate their overall execution protocols when problems arise. *See* Resp. Br. 14-16 (detailing Oklahoma's changes following the Lockett execution).

For example, when a misplaced intravenous line led to complications with Florida's 2006 execution of Angel Diaz, Florida promptly made substantial changes to its lethal injection protocol. These changes, however, did not require a change in the drugs used. *See generally Lightbourne v. McCollum*, 969 So. 2d 326, 345 (Fla. 2007) ("In reviewing the trial court's order and the facts as developed in the evidentiary hearing, we note that it is undisputed that in the execution of Angel Diaz, the intravenous lines were not functioning properly because the catheters passed through his veins in both arms and thus delivered the lethal chemicals into soft tissue,

rather than into his veins."). The Florida Supreme Court upheld the revised lethal injection protocols against a number of challenges following a thirteen-day evidentiary hearing about the Diaz execution. *See id.* at 331-32.

Problems with administration of drugs in an individual execution do not equate to problems with the selection of the drugs themselves. Indeed, since the *Lightbourne* decision—and the protocol changes it considered—Florida has executed twenty-six inmates by lethal injection without any similar complications. *See* Execution List: 1976-present, *available at www.dc.state.fl.us/oth/deathrow/execlist.html.*

IV. This Court Should Reject Petitioners' Argument That It Should Reweigh Evidence.

The litigation in Florida and the litigation below show how factual disputes should be resolved. Each side should present its best evidence, and the trial court should weigh that evidence and make appropriate findings. Then, appellate courts should review the trial court's factual findings for clear error—not substitute their own findings. *See Anderson v. City of Bessemer City, N.C.*, 470 U.S. 564, 573-74 (1985) ("If the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently."); *cf. Chavez*, 742 F.3d at 1272 ("The district court's findings, none of which are clearly

erroneous, negate any contention that Chavez's evidence shows that midazolam is not effective as an anesthetic."). Through that process, trial and appellate courts in Florida and Oklahoma determined that claim that midazolam produces unconstitutional risk cannot succeed.

Yet Petitioners ask this Court to accept their competing facts, disregard the fact-findings below, and announce as a matter of *fact*, that a particular drug in a particular protocol is unsafe and unfit for use in capital punishment. This would constitute a substantial departure from the Court's longstanding view of its role in reviewing lower court decisions. *See Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 123 (1969) ("In applying the clearly erroneous standard to the findings of a district court sitting without a jury, appellate courts must constantly have in mind that their function is not to decide factual issues de novo."). Indeed, in *Baze*, the plurality recited the trial court's finding regarding a minimal risk and, rather than independently reweighing the evidence, noted only that it "cannot say that this finding is clearly erroneous." 553 U.S. at 54 (plurality op.).

This Court should do likewise and refuse to disturb the trial court's factual findings, affirmed on appeal.

CONCLUSION

Petitioners have not met their "heavy burden" to establish that using a three-drug protocol with a 500 milligram dose of midazolam as the first drug constitutes cruel and unusual punishment. *See Baze*,

553 U.S. at 53 (plurality op.). As Florida's experience demonstrates, midazolam has proven safe and effective in rendering an inmate unconscious, just as the previous drugs did in the similar protocol approved in *Baze*. The procedures for carrying out the capital sentences in states like Oklahoma and Florida provide protections well beyond what the Eighth Amendment requires.

This Court should dismiss the petition as improvidently granted. If it reaches the merits, it should affirm.

Respectfully submitted,

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Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,

Petitioners,

v.

KEVIN J. GROSS, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF FORMER STATE ATTORNEYS GENERAL AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES iii

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. Oklahoma's Selection of Midazolam Followed a Flawed Process with Disastrous Consequences. 5

A. Oklahoma's Rushed Decision to Use Midazolam 5

B. The Execution of Clayton Lockett Demonstrates that Midazolam Does Not Reliably Induce Unconsciousness 11

C. Following the Lockett Execution, Oklahoma Revises its Execution Protocol in Scientifically Invalid Ways. 14

II. Oklahoma's Flawed Process for Selecting Midazolam Did Not Comport with the State's Responsibility to Execute Lawful Punishments. 18

A. Oklahoma's Hasty, Unscientific Process for Selecting Midazolam Violated Its Solemn Duty to Carry Out Lawful Punishments. 20

B. Amici's Concerns Are Not Assuaged By Florida's Use of Midazolam Or An Alleged Lack of Alternative Drugs. 23

CONCLUSION 25

TABLE OF AUTHORITIES

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Baze v. Rees, 553 U.S. 35 (2008) 5, 6, 12, 20, 21, 22, 23

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INTEREST OF *AMICI CURIAE*[1]

Amici are former State Attorneys General who were responsible for ensuring the execution of criminal laws and punishments, including, in some States, the death penalty. *Amici* consist of a bipartisan group ranging across the political spectrum. *Amici* include both proponents and opponents of capital punishment, but all *amici* agree that if States carry out executions, they have a solemn duty to ensure that those executions are conducted in a humane manner. *Amici* therefore have a strong interest in ensuring that States engage in a proper process in selecting a constitutional method of execution. When the method is lethal injection, as it has been in this country for over 40 years, *amici's* interest includes ensuring that drugs chosen for the States' respective lethal injection protocols are scientifically capable of causing a humane death, free from intolerable risks of severe pain and suffering.

The individual *amici* are:

- William Broaddus, who served as Attorney General of Virginia from 1985 to 1986.

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[1] Pursuant to Rule 37.6, *amici* state that no counsel for a party authored this brief in whole or in part, and no person other than *amici* and their counsel made any monetary contribution intended to fund the preparation or submission of this brief. Both parties have filed blanket letters of consent to the filing of *amicus* briefs with the Clerk's office.

- Robert Del Tufo, who served as Attorney General of New Jersey from 1990 to 1993.
- Mark Earley, who served as Attorney General of Virginia from 1998 to 2001.
- Tyrone Fahner, who served as Attorney General of Illinois from 1980 to 1983.
- Scott Harshbarger, who served as Attorney General of Massachusetts from 1991 to 1999.
- Robert Henry, who served as Attorney General of Oklahoma from 1987 to 1991. He also served as a Judge for the United States Court of Appeals for the Tenth Circuit from 1994 to 2010 and served as Chief Judge from 2008 to 2010.
- Peg Lautenschlager, who served as Attorney General of Wisconsin from 2003 to 2007.
- Vice President Walter Mondale, who served as Attorney General of Minnesota from 1960 to 1964. He subsequently served as a United States Senator from Minnesota from 1964 to 1976 and then as Vice President of the United States from 1971 to 1981.
- Jim Petro, who served as Attorney General of Ohio from 2003 to 2007. He also served as a Member of the Ohio House of Representatives from 1981 to 1984, and again from 1987 to 1990.
- Deborah Poritz, who served as Attorney General of New Jersey from 1994 to 1996.

She subsequently served as Chief Justice of the New Jersey Supreme Court from 1996 to 2006.

- Ernie Preate, who served as Attorney General of Pennsylvania from 1989 to 1995.
- Mark Shurtleff, who served as Attorney General of Utah from 2001 to 2013.
- John Van de Kamp, who served as Attorney General of California from 1983 to 1991.

SUMMARY OF ARGUMENT

As former State Attorneys General, *amici* have significant experience enforcing criminal laws and ensuring that the people's chosen punishments are carried out in a lawful manner. *Amici* consider the selection and implementation of the means of executing prisoners condemned to death to be the most solemn responsibility of state law enforcement officials. This responsibility demands serious contemplation, consideration of scientific, medical, and technical evidence, and collaboration with experts.

Oklahoma failed to meet those standards here. With execution dates set for two condemned prisoners on the same date, Oklahoma lawyers were under temporal and political pressure to go forward with the executions. When their source of pentobarbital fell through, they quickly selected midazolam to serve as the crucial first drug in a three-drug protocol, even though it is not medically equivalent to the drugs typically used for that purpose. The lawyers who made this decision did not consult scientific, medical, or

correctional experts; instead, they relied on their own internet research and conversations with officials in other States, most of whom lacked any experience with midazolam. And even after the use of midazolam contributed to what is widely considered the botched execution of Clayton Lockett, Oklahoma officials *still* failed to eliminate that drug from their protocol.

The process by which Oklahoma officials decided to use midazolam, and their subsequent entrenchment regarding that decision, stand in marked contrast to the experience of other States. Recognizing midazolam's inefficacy, at least one State has abandoned the drug altogether, another has abandoned a proposed two-drug protocol that featured midazolam, and a third has put a hold on all executions. And contrary to Oklahoma's assertion that in light of other drug shortages, it *must* use midazolam to carry out its executions, several States have conducted lawful executions without midazolam during the pendency of this very case. Even if that were not so, Oklahoma cannot justify its hurried process and resulting use of midazolam on the basis of urgency: Oklahoma's interest in enforcing punishments is not jeopardized by a short delay in carrying out the punishment and such urgency does not trump constitutional requirements.

Oklahoma's flawed process for adopting midazolam, and its refusal to meaningfully reconsider that decision, provide a case study in how state officials should *not* approach the most solemn duty of selecting the means of execution. For this reason, as well as those provided by petitioners, *amici* respectfully submit that the decision below should be reversed.

ARGUMENT

I. Oklahoma's Selection of Midazolam Followed a Flawed Process with Disastrous Consequences.

A. Oklahoma's Rushed Decision to Use Midazolam.

Like many States, Oklahoma uses a three-drug protocol to carry out executions by lethal injection. As this Court explained in *Baze v. Rees*, 553 U.S. 35, 44 (2008), the first drug in a three-drug protocol is crucial: it induces a deep, comalike unconsciousness, thus "ensur[ing] that the prisoner does not experience any pain associated with the paralysis and cardiac arrest caused by the second and third drugs," respectively. Without a proper dose of an effective first drug, "there is a substantial, constitutionally unacceptable risk" that the prisoner will suffer severe pain and suffering from the administration of the other two drugs, which generally produce paralysis and stop the prisoner's heart, respectively. *Id.* at 53. The respondents here conceded this extreme suffering would occur if the second and third drugs were administered to an aware individual. Amended Complaint ¶¶ 98-99, ECF No. 75, Answer to Amended Complaint ¶ 50, ECF No. 96.

For many years, Oklahoma's three-drug protocol began with a dose of sodium thiopental, the same drug used by Kentucky in *Baze*, to render the prisoner unconscious. J.A.114. As *Baze* explained, sodium thiopental "induces a deep, comalike unconsciousness when given in the amounts used for lethal injection"; that unconsciousness protects prisoners from an unconstitutional risk of pain and suffering from the

administration of the second and third drugs. 553 U.S. at 44. In 2010, Oklahoma became unable to obtain sodium thiopental for use in its executions. Instead, Oklahoma used pentobarbital, a barbiturate similar to sodium thiopental. J.A.115; *see* J.A.153; *Pavatt v. Jones*, 627 F.3d 1336, 1337 (10th Cir. 2010).

In March 2014, Oklahoma officials were preparing for the executions of Clayton Lockett and Charles Warner, which were scheduled for March 20 and March 27, respectively. Supp. Vol. III[2] at 1, 3. On Monday, March 17, the Assistant Attorney General defending the State in the death penalty appeals of Lockett and Warner, advised the Oklahoma Court of Criminal Appeals (OCCA) that the commitment the State had from a pharmacy supplying its drugs "fell through." Supp. Vol. III at 13. According to the Assistant Attorney General, pentobarbital was in "short supply." (*Id.*) As a result, the Assistant Attorney General informed the OCCA that the Oklahoma Department of Corrections (ODOC) might "revise its execution protocol to incorporate drugs that are currently available, and obtainable, by ODOC on the open market." Supp. Vol. III at 14.

The following day, the OCCA rescheduled the Lockett and Warner executions for late April 2014. Supp. Vol. III at 37. Both executions were ultimately scheduled on April 29, 2014 on order of Oklahoma's Governor. Exec. Order No. 2014-08, Governor of

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[2] "Supp. Vol. __" refers to the supplemental record on appeal filed in the 10th Circuit proceeding.

Oklahoma (Apr. 22, 2014) *available at* https://www.sos.ok.gov/documents/executive/939.pdf.

Oklahoma officials did not take this additional time to engage in a meaningful analysis of the merits and risks associated with potential substitutes for pentobarbital. Instead, *just four days after* informing the OCCA of the drug shortage, Oklahoma State Penitentiary Warden Anita Trammell, a respondent here, signed a new execution protocol effective March 21, 2014. That protocol, for the first time, included midazolam as an alternative substitute for sodium thiopental or pentobarbital in the three-drug execution protocol.[3]

As petitioners have explained (Pet'rs' Br. at 11-17), midazolam has little in common with sodium thiopental and pentobarbital. Midazolam is not a barbiturate; instead, it belongs to a class of drugs called benzodiazepines, and it is meant primarily to reduce anxiety and to produce mild sedation. J.A.203; J.A.263. Midazolam has no analgesic, or pain-relieving, qualities, and it is not approved by the FDA for use as a sole anesthesic. J.A.204-05, 223; J.A.260-61; J.A.340-41; Brief of Appellant at 8, *Warner v. Gross*, 776 F.3d 721 (10th Cir. 2015) (No. 14-6244) ["Appellant Br."] (citing Tr. 12/19/2014 at 661:8-9). In the district court, multiple experts testified that while midazolam is generally used to reduce anxiety *before* surgery, it does not work to

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[3] The drug protocol was altered again in April 2014 to increase the dose of midazolam. The higher, 100 milligram dose was used in the Lockett execution, discussed *infra*.

produce and reliably maintain general anesthesia and so should not be used as the sole agent to render a patient unconscious during painful surgical procedures. Pet'rs' Br. at 12-16.

Two of midazolam's properties are particularly relevant to Oklahoma's decision to adopt the drug. *First*, unlike barbiturates such as sodium thiopental and pentobarbital, midazolam has a "ceiling effect": after a certain dosage, the administration of additional midazolam does not produce an additional effect. J.A.206; Pet'rs' Br. at 16 n.17 (citing Tr. 343, 664). Thus, as multiple experts testified, no amount of midazolam will induce a coma or electrical brain silence. J.A.207-09; *see also* J.A.263-64. Midazolam's ceiling effect, coupled with its lack of analgesic effect, means that midazolam cannot reliably produce and maintain the level of unconsciousness necessary for induction of painful stimuli. Pet'rs' Br. at 16-17 (citing Tr. 145).

Second, midazolam carries a risk of a "paradoxical" effect. Instead of causing the sedation for which it is intended, midazolam may cause a person to experience "agitation, combativeness, and anxiety." J.A.210; *see also* J.A.263-64; Appellant Br. at 15 (citing Tr. 12/19/2014 at 669:3-5). This reaction is more likely in individuals who (like petitioners and many death row inmates) exhibit "behaviors such as aggression, impulsivity, substance abuse, and [those] suffering from other psychiatric disorders or psychological disturbances." Pet'rs' Br. at 14 n.15 (citing Tr. 116). A paradoxical reaction may occur in between 1-10% of individuals administered the drug. J.A.210; Appellant Br. at 15 (citing Tr. 12/18/2014 at 348:17-25).

Despite the scientific consensus concerning midazolam's unsuitability, Oklahoma officials decided to substitute it as the crucial first drug in the three-drug protocol. This was not the result of lengthy deliberation and study by medical or correctional professionals. To the contrary, over the course of a few days in March 2014, a group of government lawyers from the ODOC and Attorney General's Office made the decision while under significant time and political pressure. *See* J.A.147. For example, the General Counsel of the ODOC at the time testified that "there were calls from the Governor's office . . . we would get word from the Attorney General's Office that we better hurry up and do something." J.A.148.

The lawyers ran the process *even though* Oklahoma's execution protocol gave Warden Trammell "sole discretion as to which lethal agent will be used for the scheduled execution." Supp. Vol. I at 44 § IX.C.7; Pet'rs' Br. at 9. In fact, Trammell "wasn't really brought into" the decision whether to adopt midazolam. Appellant Br. at 23 (quoting Supp. Vol. II at 214:1). She did not "draft the new protocol," and she conceded that she knew nothing about midazolam and did no independent research. J.A.152-53.

Nor did the lawyers themselves engage in serious research regarding midazolam or consult scientists or medical experts. For example, the former ODOC General Counsel testified that "they" decided on midazolam because "we knew midazolam had the same properties as pentobarbital as far as sedation goes." J.A.145. He testified that he received this information – which is incorrect, *see supra* – from the Attorney

General's office, his own internet research, and correctional personnel in other states. In particular, he testified that he "looked on-line . . . . Went past the key Wiki leaks, Wiki leaks or whatever it is, and I did find out that when administered, Midazolam would . . . render a person unconscious." Appellant Br. at 24 (citing Supp. Vol. II at 211:19-22). The General Counsel further testified that he was unaware of criticism of the information provided on such websites. J.A.147. In addition, he testified that he did not uncover any information about the risks of a paradoxical reaction or the ceiling effect. J.A.149.

The ODOC General Counsel also stated that Oklahoma officials spoke with officials from Illinois, Arizona, and Texas "one day," though none of those consultations (or any others) occurred in person. Appellant Br. at 25 (citing Supp. Vol. II at 187:20-21, 192:19). And in fact, *none* of those States were using midazolam to carry out executions at this time: Illinois abolished the death penalty in 2011,[4] Arizona first used midazolam to carry out a death sentence in July 2014,[5]

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[4] *See* Christopher Wills, *Illinois Gov. Pat Quinn Abolishes Death Penalty, Clears Death Row*, Wash. Post, Mar. 9, 2011, *available at* http://www.washingtonpost.com/wp-dyn/content/article/2011/03/09/AR2011030900319.html.

[5] *See* Ben Brumfield, *Arizona Execution Raises Questions Over Novel Lethal Injections*, CNN, July 25, 2014, http://www.cnn.com/2014/07/24/justice/lethal-injection-controversy/; As discussed, *supra*, Arizona has stayed execution pending the investigation into the Wood execution.

and Texas does not use midazolam in its protocol.[6] Finally, the ODOC General Counsel consulted with the General Counsel in Ohio, who told him that the Ohio execution of Dennis McGuire, which involved a combination of midazolam and hydromorphone, "really didn't take that long" and "didn't take as long as what the new[s] stories were." Appellant Br. at 25 (quoting Supp. Vol. II at 212:6-8). The "news stories" to which the Ohio official referred recounted that McGuire gasped for breath, choked, and struggled against his restraints for 26 minutes before dying.[7] Yet, Oklahoma officials did not delay, adopting the midazolom protocol on March 21, 2014.

B. The Execution of Clayton Lockett Demonstrates that Midazolam Does Not Reliably Induce Unconsciousness.

Armed with its newly developed protocol, Oklahoma carried out the execution of Clayton Lockett on April 29, 2014. The execution began with 100 milligrams of midazolam, followed by 50 milligrams of vecuronium bromide, a paralytic, and 200 milliequivalents of potassium chloride, which "interferes with the

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[6] *See* Texas Department of Criminal Justice—Execution Procedures, http://www.fdp.dk/uk/tdcj/exe-proc.htm (last visited Mar. 12, 2015).

[7] *See* Alan Johnson, *Dennis McGuire's Execution was Not 'Humane,' Doctor Days*, Columbus Dispatch, Aug. 13, 2014, *available at* http://tinyurl.com/mmadmwh. As discussed *supra*, following the McGuire execution, Ohio abandoned its use of midazolam.

electrical signals that stimulate the contractions of the heart, inducing cardiac arrest." *Baze*, 553 U.S. at 44.

The Lockett execution did not go smoothly. Warden Trammel described it as a "bloody mess," Appellant Br. at 4 n.4 (citing Supp. Vol. II at 88), while a paramedic referred to the entire process as "such a cluster," Appellant Br. at 16 & n.10 (quoting Supp. Vol. VI at 400:15-16).[8] Following the execution, Governor Fallin appointed the Secretary of Safety and Security and Department of Public Safety ("DPS") Commissioner to conduct an independent review of the execution.[9] Although the DPS review did not determine the appropriateness of any of the drugs or dosages in Oklahoma's three-drug protocol, *see* J.A.411-12, its findings regarding the Lockett execution speak volumes about the inefficacy of midazolam.[10]

As the DPS review explains, the execution began with administration of the full dose of midazolam. Seven minutes later, the physician determined that

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[8] *See generally* Cary Aspinwall & Ziva Branstetter, *Records Reveal Lack of Protocol in Clayton Lockett's Oklahoma Execution*, Tulsa World, Mar. 16, 2015, *available at* http://www.tulsaworld.com/homepage1/records-reveal-lack-of-protocol-in-clayton-lockett-s-oklahoma/article_e4f17853-160c-530a-9f36-928a0fd9f605.html.

[9] *See* Oklahoma Dep't of Pub. Safety, *The Execution of Clayton D. Lockett, Case Number 14-0189SI: Executive Summary*, *available at* http://tinyurl.com/k5nlmp6 (last visited Mar. 12, 2015).

[10] Indeed, the agent in charge of the investigation, Captain Jason Holt, did not see investigation into midazolam as the mission of the governor's executive order. J.A.424-25.

Lockett was unconscious. J.A.392-93. The full dose of vecuronium bromide and the "majority" of the potassium chloride were then administered. J.A.393 However, at that time, Lockett "began to move and make sounds on the execution table." *Id.* While witnesses' accounts differed somewhat, witnesses reported that Lockett writhed and strained against his restraints, mumbled, spoke, repeatedly tried to raise his head and shoulders from the gurney, and was "kicking" and "bucking . . like he wanted to get off . the gurney." J.A.214; Appellant Br. at 19 (quoting Tr. 12/17/2014 206:7-8).

Around this time, the physician inspected the IV insertion site and determined "there was an issue." J.A.393. The physician and paramedic attempted additional IV access, the member of the execution team charged with administering the drugs stopped administering the potassium chloride, and officials discussed how to proceed. J.A.393-95. The execution was then stopped. J.A.395. Ten minutes later – approximately 43 minutes after the execution had begun – Lockett was pronounced dead. *Id.*

The DPS investigation concluded that "the viability of the IV access point was the single greatest factor that contributed to the difficulty in administering the execution drugs." J.A.398. In particular, the failure of IV access meant that the drugs infiltrated into Lockett's tissue. Although midazolam has a relatively rapid rate of absorption even when injected intramuscularly, Appellant Br. at 18 (citing Tr. 12/17/2014 at 116), the paralyzing agent, vecuronium bromide, is much less effective when delivered through

tissue, Appellant Br. at 18 (citing Tr. 12/17/2014 at 120). Because at least some of the vecuronium bromide was delivered through tissue, Lockett was not fully paralyzed, allowing him to speak and move.

The failure of the paralytic agent reveals that the first drug, midazolam, did not keep Lockett in a deep, coma-like state of unconsciousness. As medical experts explained in the district court, an unconscious person does not "make efforts to speak to you," "rise up off the gurney," or gesticulate "with their torso." J.A.216; *see* J.A.338-40, 345. And because Lockett regained consciousness, administration of the second drug, vecuronium bromide, likely caused him to experience a feeling of "gradual suffocation, the inability to draw one's breath, air hunger, and a progressive suffocation." J.A.214-15. Similarly, administration of the third drug, potassium chloride, which has been described as "liquid fire," likely caused Lockett severe pain. J.A.215; *see also* Appellant Br. at 19 (quoting Tr. 12/22/2014 at 15:1-3 (district court stated that "Lockett was surely experiencing all of the mental pain that is inevitable in the execution process as well as serious physical discomfort if not serious physical pain")).

C. Following the Lockett Execution, Oklahoma Revises its Execution Protocol in Scientifically Invalid Ways.

Oklahoma responded to the Lockett execution and the DPS report by issuing a revised execution protocol in September 2014. For example, Oklahoma now requires a backup set of lethal drugs, in the event there is a problem with the administration of the first set of drugs. Oklahoma also changed the required training

for some personnel and now requires documentation of that training. In addition, Oklahoma altered the procedures for monitoring consciousness during an execution. Supp. Vol. X at 335-39 (Plaintiff's Exh. 68 (Sept. 30, 2014 protocol)). Oklahoma also renovated the three rooms associated with executions: the execution chamber, the chemical room, and the witness viewing area. It enlarged the chemical room and installed a camera system and an updated communication system. In enlarging the chemical room, the chamber was reduced in size, and the number of media witnesses who may view executions was limited to five.[11] Oklahoma also set out procedures and purchased new equipment designed to improve IV access and IV observations.

Oklahoma did not, however, revisit the use of midazolam, other than to increase the suggested dosage from 100 milligrams to 500 milligrams. *Compare* Supp. Vol. I at 58-77 (Plaintiff's Exh. 4 (Apr. 14, 2014 protocol)), *with* Supp. Vol. X at 297-341 (Plaintiff's Exh. 68 (Sept. 30, 2014 protocol)). As explained *supra*, because of midazolam's ceiling effect, increasing the dosage will *not* increase the likelihood that midazolam will produce unconsciousness. In fact, when Arizona executed Joseph Wood in July 2014, it administered 750 milligrams of midazolam, 50% more than Oklahoma's

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[11] Supp. Vol. X at 125-26 (Crow Dep. Nov. 26, 2014, 120:17-121:21); *Oklahoma Unveils New Execution Protocols to Replace Those that Led to Inmates 43-Minute Death*, Associated Press, Sept. 30, 2014, *available at* http://tinyurl.com/mtrzysp.

revised protocol requires.[12] Wood nonetheless gasped and struggled to breathe during the execution, which took almost two hours to complete.[13]

Oklahoma's refusal to reconsider its use of midazolam is consistent with its process for adopting the drug in the first place. Oklahoma officials once again failed to consult objective scientific and medical experts, and they failed to take account of midazolam's known ceiling effect, as demonstrated by the Wood execution.[14] *See* J.A.158-60.

Oklahoma's response to the Lockett execution stands in marked contrast to the experience of other States. For example, as previously noted, Ohio used a combination of midazolam and hydromorphone to execute Dennis McGuire in January 2014. McGuire chocked and gasped before he died in an execution that lasted over 25 minutes. *See supra* at 10. Following an investigation, Ohio abandoned its use of midazolam, issuing a new

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[12] Press Release, Arizona Dep't of Corrections, Independent Review Process for Wood Execution Underway, Aug. 1, 2014, *available at* http://tinyurl.com/mhk4hx6.

[13] Michael Kiefer, *Reporter Describes Arizona Execution: 2 Hours, 640 Gasps*, The Republic, Nov. 6, 2014, *available at* http://tinyurl.com/lnaz6k8.

[14] One witness testified that Oklahoma officials consulted Dr. R. Lee Evans, who became the State's testifying expert in this case. Supp. Vol. X at 38-39 (Crow Dep. Nov. 26, 2014, 33:16-34:6). However, it appears that Dr. Evans was selected because he had testified in support of Florida's use of midazolam. To *amicis'* knowledge, Oklahoma officials did not seek out any objective medical or scientific experts.

execution protocol using thiopental sodium and pentobarbital for its executions.[15] Arizona, moreover, has put all executions on hold after its flawed execution of Joseph Wood, who gasped and snored for nearly two hours before ultimately dying.[16] Lastly, in light of the botched executions in Ohio and Arizona, the Kentucky Attorney General announced that Kentucky was abandoning its proposed two-drug execution method, which would have used midazolam.[17]

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[15] Mark Berman, *Ohio Drops Controversial Lethal Injection Drugs, Postpones Upcoming Execution*, Wash. Post, Jan. 9, 2015, *available at* http://www.washingtonpost.com/news/post-nation/wp/2015/01/09/ohio-drops-controversial-lethal-injection-drug-postpones-upcoming-execution/. Ohio has recognized that the need to find these drugs may take some time, and it has therefore postponed executions scheduled for this calendar year. Mark Berman, *Ohio Delays all Executions Scheduled for 2015*, Wash. Post, Jan. 31, 2015, *available at* http://tinyurl.com/kkhagob. However, as discussed *infra*, other States have continued to carry out lawful executions with drugs other than midazolam, demonstrating that state officials need not choose between their responsibility to carry out executions and their duty to ensure that those executions proceed in a humane and constitutional manner.

[16] Michael Kiefer, *Arizona to Change Drugs Used for Executions*, USA Today, Dec. 23, 2014, *available at* http://www.usatoday.com/story/news/nation/2014/12/23/report-arizona-execution-change-drugs/20796903/.

[17] Brett Barrouquere, *Kentucky Drops 2-Drug Executions, Reworking Method*, Daily Mail, Nov. 14, 2014, *available at* http://www.dailymail.co.uk/wires/ap/article-2834665/Kentucky-drops-2-drug-executions-reworking-method.html.

II. Oklahoma's Flawed Process for Selecting Midazolam Did Not Comport with the State's Responsibility to Execute Lawful Punishments.

As former State Attorneys General, *amici* have served as chief law enforcement officers of their respective States, charged with carrying out punishments imposed by the judiciary. *See, e.g.*, Nat'l Ass'n of Attorneys General, *2014 Strategic Plan: Setting the Course* at 4 (2014), *available at* http://www.naag.org/assets/files/pdf/policy/2014%20NAAG%20Strategic%20Plan.pdf; Cal. Const. art V, § 13 (State Attorney General has duty to "see that the laws of the State are uniformly and adequately enforced."). With that enforcement responsibility comes the corollary obligation to ensure that punishments are lawful. Indeed, attorneys general have long recognized their obligation to interpret and execute the law in a lawful and constitutional manner.[18] And *amici*, too, considered it their solemn duty to ensure that such

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[18] *See, e.g.*, Walter Dellinger & H. Jefferson Powell, *The Constitutionality of the Bank Bill: The Attorney General's First Constitutional Law Opinions*, 44 Duke L.J. 110, 112-13 (1994) ("Randolph, far more than either Hamilton or Jefferson, made a conscious attempt to distinguish his professional judgment about the legal question of constitutionality from his political judgment about the desirability of a national bank."); Attorney General Caleb Cushing, Office and Duties of Attorney General, 6 Op. Att'y Gen. 326, 334 (1854) (referring to the attorney general's "solemn responsibilities of conscience and of legal obligation"); Letter from Attorney General William Wirt to Secretary of War, John. C. Calhoun (Feb. 3, 1820) (noting his obligation as attorney general to "decide a question of law with the impartiality and integrity which characterizes the judician").

punishments complied with both the United States Constitution and their respective state constitutions.[19]

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[19] *See, e.g.*, Georgia Attorney General Mission Statement, *available at* http://law.ga.gov/mission-statement (last visited Mar. 12, 2015) ("The mission of the Department of Law is to serve the citizens of the State of Georgia by . . . honorably and vigorously carrying out the constitutional and statutory responsibilities of the Attorney General."); About the Office, Virginia Attorney General, *available at* tinyurl.com/kfvewcq (last visited Mar. 13, 2015) ("The Attorney General has the duty and power to . . . Support the Constitution of the United States and the Constitutional of Virginia."); Ohio Const. art. III, § 6 (Governor "shall see that the laws are faithfully executed"); Mass. Const. part 2, ch. VI, art. VI ("All the laws which have heretofore been adopted, used, and approved . . . shall still remain and be in full force . . . such parts only excepted as are repugnant to the rights of liberties contained in this constitution); N.J. Const. art. VII, § I, ¶ 1 ("Every State officer . . . shall take and subscribe an oath or affirmation to support the Constitution of this State and of the United States and to perform the duties of his office faithfully, impartially and justly to the best of his ability."); Minn. Const. art. V, § 6 ("Each [executive] officer . . . shall take an oath or affirmation to support the constitution of the United States and of this state and to discharge faithfully the duties of his office to the best of his judgment and ability."); Okla. Const. art. 15, § 1 ("All public officers ... shall take and subscribe to" an "oath or affirmation" affirming that they will "support, obey, and defend the Constitution of the United States, and the Constitution of the State of Oklahoma"); Ill. Const. art. XIII, § 3 ("Each prospective holder of a State office" shall affirm that they "solemnly swear (affirm) that [they] will support the Constitution of the United States and the Constitution of the State of Illinois, and that [they] will faithfully discharge the duties of the office of .... to the best of [their] ability."); Wis. Const. art. IV § 28 (Executive officers "shall . take and subscribe an oath or affirmation to support the constitution of the United States and the constitution of the state

Amici have paid particular care to the death penalty, and strongly believe that States should not move forward with executions in the absence of drugs that can assure the Court and the citizens of their States that the executions will not cause needless pain in violation of the United States Constitution.

A. Oklahoma's Hasty, Unscientific Process for Selecting Midazolam Violated Its Solemn Duty to Carry Out Lawful Punishments.

Oklahoma's hasty, non-science-driven process for selecting midazolam as the first drug in its three-drug protocol did not cohere with its solemn duty to ensure its punishments are lawful.

Amici recognize that when States carry out executions using a three-drug lethal injection protocol – as Oklahoma plans to do here – the first drug should induce a "deep, comalike unconsciousness" in order to render the prisoner insensate to the known and severe pain and suffering caused by the second and third drugs. *Baze*, 553 U.S. at 44; *supra* at 4. The Supreme Court in *Baze*, for example, found that sodium thiopental – the first drug in the three-drug protocol at issue in that case – induced such a state of unconsciousness. 553 U.S. at 44. The first drug's importance is highlighted by the fact that it would be constitutionally impermissible to administer the second and third drugs to a conscious prisoner because to do so would expose the prisoner to an "objectively intolerable

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of Wisconsin, and faithfully to discharge the duties of their respective offices to the best of their ability").

risk of harm" and would surely cause "needless suffering." *Baze*, 553 U.S. at 50 (*quoting Farmer v. Brennan*, 511 U.S. 825, 842 (1994) and *Helling v. McKinney*, 509 U.S. 25, 33, 34-35 (1993)). To avoid running afoul of the Eighth Amendment, then, it is crucial that the first drug reliably produce a deep, coma-like unconsciousness that is maintained throughout the execution. This makes the State's selection of the first drug – the anesthetic – an exceedingly important task, one which should involve careful research and thoughtful deliberation, including consultation with experts in the relevant medical and scientific fields.

Amici believe this case presents the Court with strong evidence that Oklahoma failed to conduct careful research and engage in the appropriate process when it selected midazolam as the first drug in its protocol. Oklahoma did not consult *any* scientists or experts when choosing midazolam. *See supra* at 10-11. Far from careful expert consultation, Oklahoma's selection of midazolam was a product of a rushed, non-science-driven process. *See supra* at 9-12. Indeed, the primary personnel involved in choosing midazolam were the former General Counsel for Oklahoma Department of Corrections, and members of the Oklahoma Attorney General's office, all lawyers. *See supra* at 9-10. And political and time pressure rushed the drug selection, forcing the resort to "Wiki leaks or whatever it is" as a main basis for the State's selection of midazolam. *See supra* at 9.

Amici believe that such a hurried, unscientific process does not suffice. Rather, the state agencies

statutorily charged with carrying out executions – *not* the attorneys representing those agencies – bear responsibility for conducting the necessary medical and scientific research to determine which drugs are appropriate and available for use in executions. Such research may involve meeting with experts, reviewing relevant studies with those experts, or even working with laboratory scientists.[20] *Amici* believe that based on such research, the relevant agencies should engage in reasoned deliberation to select the appropriate drugs for lethal injection. *Cf. Kentucky Holding Public Hearing on Execution Method*, Associated Press, Sept. 25, 2012, *available at* http://www.wkyt.com/home/headlines/Ky-holding-public-hearing-on-execution-method-171112591.html (Kentucky officials hold public hearing on new proposed execution method).

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[20] *See, e.g.*, Mark Berman, *Georgia Postpones First Execution of a Woman Since WWII Due to Issues With Legal Injection Drugs*, Wash. Post, Mar. 2, 2015, *available at* http://tinyurl.com/l3k5bl5 (execution postponed after drugs sent to independent lab for potency testing before execution); *Indiana Use of New Execution Drug Draws Opposition*, Associated Press, May 31, 2014, *available at* http://www.cbsnews.com/news/indiana-use-of-new-execution-drug-draws-opposition/ (Indiana consulted with pharmacists and experts before choosing its death penalty anesthetic); *Baze*, 553 U.S. at 42 ("In 1977, legislators in Oklahoma, after consulting with the head of the anesthesiology department at the University of Oklahoma College of Medicine, introduced the first bill proposing lethal injection as the State's method of execution.").

B. Amici's Concerns Are Not Assuaged By Florida's Use of Midazolam Or An Alleged Lack of Alternative Drugs.

Amici's concerns are not assuaged by the fact that Florida uses midazolam as the first drug in its three-drug execution protocol. Like Oklahoma, Florida, for its second drug, administers a paralytic that would render a prisoner unable to move even if he were awake and conscious. This makes it impossible for observers to detect any pain and suffering the prisoner may be undergoing. *See Warner v. Gross*, 135 S. Ct. 824, 827 (2015) (Sotomayor, J., dissenting from denial of stay) ("[Florida's] apparent success with that method is subject to question because the injection of the paralytic . . . may mask the ineffectiveness of midazolam as an anesthetic: The inmate may be fully conscious but unable to move."); *Baze*, 553 U.S. at 71 (Stevens, J., concurring in judgment) (paralytic "masks any outward sign of distress").

Nor are *amici*'s concerns assuaged by an assertion that Oklahoma has no choice but to use midazolam because of the lack of alternatives. States carry out lawful executions by lethal injection on a regular basis without using midazolam. Indeed, since Clayton Lockett's execution on April 29, 2014, three different States have executed 18 prisoners without midazolam.[21]

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[21] *See* Execution List 2015, *Death Penalty Information Center*, tinyurl.com/mv6je7j (last visited Mar. 13, 2015); Execution List 2014, *Death Penalty Information Center*, *available at* http://tinyurl.com/o58d87p (last visited Mar. 13, 2015). Four of those executions occurred after this Court granted certiorari in

Thus, Oklahoma and its *amici* cannot plausibly contend that a three-drug protocol beginning with midazolam is the "best available mechanism" to carry out lethal injection, Brief in Opposition at 5, or that a ruling in petitioners' favor will render the State unable to carry out lawful executions.

Even if alternatives to midazolam were not immediately available, urgency cannot justify Oklahoma's rushed and haphazard decisionmaking process. While *amici* appreciate and endorse the State's interest in enforcing its criminal laws and carrying out punishments pursuant to those laws, *amici* do not believe that interest is jeopardized by delaying executions for a short period of time to ensure they are carried out in a humane and lawful manner. *Amici*, furthermore, do not believe such urgency could justify imposing a punishment that does not cohere with the Constitution, even assuming the State's interest in carrying out punishments were jeopardized.

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this case. *See* Execution List 2015, *Death Penalty Information Center*, *available at* tinyurl.com/mv6je7j.

CONCLUSION

For the foregoing reasons, the judgment of the Tenth Circuit should be reversed.

Respectfully submitted,

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RICHARD E. GLOSSIP, ET AL.,

Petitioners,

v.

KEVIN J. GROSS, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF OF THE INNOCENCE PROJECT AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

Page

TABLE OF CITED AUTHORITIES ii

INTEREST OF *AMICUS CURIAE* 1

INTRODUCTION AND SUMMARY OF ARGUMENT. 3

ARGUMENT.... 9

I. SCIENTIFIC EVIDENCE MUST ADHERE TO SCIENTIFIC PRINCIPLES OF TESTING AND VALIDATION TO BE ADMISSIBLE . . 9

II. THE DISTRICT COURT ABUSED ITS DISCRETION BY ADMITTING PATENTLY UNRELIABLE SCIENTIFIC TESTIMONY 19

CONCLUSION 27

TABLE OF CITED AUTHORITIES

Page

CASES

Ake v. Oklahoma,
470 U.S. 68 (1985). 4

Alison v. McGhan Medical Corp.,
184 F.3d 1300 (8th Cir. 1999). 18

Baze v. Rees,
553 U.S. 35 (2008) 6

Bradley v. Brown,
42 F.3d 434 (7th Cir. 1994). 18, 21

Clark v. Takata Corp.,
192 F.3d 750 (7th Cir. 1999). 22

Daubert v. Merrell Dow Pharm., Inc.,
509 U.S. 579 (1993). . . . . *passim*

Dodge v. Cotter Corp.,
328 F.3d 1212 (10th Cir. 2003). 21

Gen. Elec. Co. v. Joiner,
522 U.S. 136 (1997). . . . 19, 20, 21, 23

Goebel v. Denver & Rio Grande Western R.R. Co.,
215 F.3d 1083 (10th Cir. 2000). . 22

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Page

Henry v. St. Croix Alumina, LLC.,
572 F. App'x 114 (3d Cir. 2014) 17

Hinton v. Alabama,
134 S. Ct. 1081 (2014) 5

Jinro America Inc. v. Secure Investments, Inc.,
266 F.3d 993 (9th Cir. 2001) 19

Kumho Tire Co., Ltd. v. Carmichael,
526 U.S. 137 (1999) 19, 20, 21

Marsh v. W.R. Grace & Co.,
80 F. App'x 883 (4th Cir. 2003) 17

McClain v. Metabolife Intern., Inc.,
401 F.3d 1233 (11th Cir. 2005) . . . 24, 26

Melendez-Diaz v. Massachusetts,
557 U.S. 305 (2009) 5

Moore v. Ashland Chemical, Inc.,
151 F.3d 269 (5th Cir. 1998) . . .16, 17, 26

Peterson v. Grisham,
594 F.3d 723 (10th Cir. 2010) 15

Polski v. Quigley Corp.,
538 F.3d 836 (8th Cir. 2008) . 17

Cited Authorities

Page

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78 F.3d 316 (7th Cir. 1996) 10

Ruggiero v. Warner-Lambert Co.,
424 F.3d 249 (2d Cir. 2005) 17

State v. Carlson,
267 N.W.2d 170 (Minn. 1978) 13

Tauto v. Brown,
85 F. App'x 674 (10th Cir. 2003) 21

United States v. Cyphers,
553 F.2d 1064 (7th Cir. 1977) 12-13

United States v. Frazier,
387 F.3d 1244 (11th Cir. 2004) 5, 23

United States v. Johnsted,
30 F. Supp. 3d 814 (W.D. Wis. 2013) 4

Vargas v. Lee,
317 F.3d 498 (5th Cir. 2003) 24

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Cited Authorities

Page

STATUTES AND OTHER AUTHORITIES

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Sup. Ct. R. 37.6 1

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Cited Authorities

Page

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Paul C. Giannelli, *Scientific Evidence in Criminal Prosecutions*, 137 MIL. L. REV. 167 (1992) . . 4

INTEREST OF *AMICUS CURIAE*[1]

The Innocence Project is an organization dedicated to providing pro bono legal and related investigative services to prisoners for whom evidence discovered post-conviction can provide proof of innocence. The Innocence Project is dedicated to improving the accuracy and reliability of the criminal justice system in future cases. Drawing on the lessons from cases in which innocent persons were convicted, the Innocence Project promotes study and reform designed to enhance the truth-seeking function of the criminal justice system, including to ensure that future wrongful convictions are prevented.

The Innocence Project pioneered the DNA model that has exonerated over 300 innocent and wrongfully convicted persons, and has served as counsel in many of these cases. Today, DNA test

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[1] The parties have consented to the filing of this brief. Petitioners and Respondents have filed with the Clerk of the Court letters granting blanket consent to the filing of *amicus curiae* briefs.

Pursuant to Supreme Court Rule 37.6, counsel for *amicus* certifies that no counsel for a party authored this brief in whole or in part, and no party or its counsel made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus*, its members, or its counsel made a monetary contribution to this brief's preparation or submission.

results are widely understood by the public and accepted as evidence at trial, in large part because DNA testing was developed through rigorous scientific research at leading institutions. But not all purportedly scientific evidence admitted at trial has undergone sufficiently rigorous scientific evaluation, including of the underlying data and methodology utilized by expert witnesses. Indeed, in nearly half of the over 300 exonerations secured through post-conviction DNA evidence, the admission of unreliable expert "scientific" evidence—such as hair analysis, fingerprint analysis, and more—has played a role in convicting the innocent.

Moreover, the impact of wrongly admitted, unreliable scientific evidence is not limited to the conviction of the innocent. Executions in the United States rely on various ever-changing combinations of drugs, despite a lack of scientific evidence supporting their effectiveness. The Innocence Project has a strong interest in ensuring that scientific expert testimony is accurate and reliable throughout the criminal justice system. This interest is implicated by the trial court's impermissible dependence on unreliable scientific evidence proffered by Respondents' sole expert witness to sustain the constitutionality of a three-drug lethal injection protocol, where well-established scientific consensus holds that the first drug has no pain-relieving properties and cannot reliably produce deep, coma-like unconsciousness, and it is undisputed that there

is a constitutionally unacceptable risk of pain and suffering from administration of the second and third drugs to a conscious prisoner.

INTRODUCTION AND SUMMARY OF ARGUMENT

This Court has long recognized the importance of scientific evidence in our judicial system and the need for that evidence to be "reliable." *Daubert v. Merrell Dow Pharm., Inc.*, 509 U.S. 579, 590 (1993). Scientific experts are permitted to testify as to their opinions regarding the conclusions to be drawn from a particular set of facts if those conclusions can be given to a reasonable degree of scientific certainty. *Daubert* made clear that courts have not only the power but also the obligation to fulfill this "gatekeeper" function. *Id.* at 589. In so doing, it also articulated standards for assessing the reliability of scientific evidence. These standards are intended to ensure that only evidence grounded in the scientific method—that is, scientifically valid principles of testing and validation—is admitted as expert evidence. These principles include empirical testing methods, peer review, and the existence of objective standards controlling the technique's operation. *Daubert*, 509 U.S. at 593-94; *see also* FED. R. EVID. 702(c) (expert testimony must be "the product of reliable principles and methods"). These principles are "meant to be helpful, not definitive," with the overarching inquiry being "the scientific validity—

and thus the evidentiary relevance and reliability—of the principles that underlie a proposed submission." *United States v. Johnsted*, 30 F. Supp. 3d 814, 817 (W.D. Wis. 2013); *Daubert*, 509 U.S. at 590 n.9 ("In a case involving scientific evidence, evidentiary reliability will be based upon scientific validity.").

Distinguishing between reliable and false scientific evidence is especially critical, given the special weight afforded to scientific evidence. Indeed, this Court has acknowledged the special deference that factfinders grant to scientific evidence offered by expert witnesses. *See, e.g.*, *Daubert*, 509 U.S. at 595 ("Expert evidence can be both powerful and quite misleading because of the difficulty in evaluating it."); *see also Ake v. Oklahoma*, 470 U.S. 68, 81 n.7 (1985) ("[T]estimony emanating from the depth and scope of specialized knowledge is very impressive to a jury. The same testimony from another source can have less effect.") (internal citation omitted). Similarly, a survey of judges and lawyers found that 75% of them believe judges accord greater credibility to scientific evidence.[2] Given these statistics, "[t]he importance of *Daubert*'s gatekeeping requirement cannot be overstated."

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[2] Paul C. Giannelli, *Scientific Evidence in Criminal Prosecutions*, 137 MIL. L. REV. 167, 173 (1992).

United States v. Frazier, 387 F.3d 1244, 1260 (11th Cir. 2004) (en banc).[3]

Reliance on scientific evidence played a central role in the decisions by the lower courts in this case as well. Petitioners face execution by lethal injection through a three-drug protocol consisting of 500 milligrams of midazolam, 100 milligrams of a paralytic,[4] and 240 milliequivalents of potassium chloride. The stated purpose of the first drug, midazolam, is to render the prisoner unconscious and insensate to pain. Petitioners' experts, however, presented well-referenced scientific evidence showing that midazolam has no analgesic effect, has a ceiling effect (that is, larger doses do not increase its effect), and at times causes a paradoxical reaction, creating agitation instead of sedation. They also presented

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[3] Indeed, this Court has recently acknowledged the threat that unvalidated and unreliable "scientific" evidence has on the fair administration of justice. *Hinton v. Alabama*, 134 S. Ct. 1081, 1090 (2014) ("[W]e have recognized the threat to fair criminal trials posed by the potential for incompetent or fraudulent prosecution forensics experts, noting that '[s]erious deficiencies have been found in the forensic evidence used in criminal trials... One study of cases in which exonerating evidence resulted in the overturning of criminal convictions concluded that invalid forensic testimony contributed to the convictions in 60% of the cases.'") (citing *Melendez-Diaz v. Massachusetts*, 557 U.S. 305, 319 (2009)).

[4] Paralytics include pancuronium bromide, vecuronium bromide, and rocuronium bromide.

scientific evidence showing that midazolam is not effective in keeping a person sedated when faced with noxious stimuli.[5] This Court has already held that pancuronium bromide and potassium chloride, administered to a prisoner who is not unconscious, would cause a "substantial, constitutionally unacceptable risk of suffocation ... and pain." *Baze v. Rees*, 553 U.S. 35, 53 (2008). Because of its inherent characteristics, Petitioners argue that midazolam cannot perform its role in the execution protocol, namely, keeping the prisoner unconscious and insensate to pain while the lethal drugs are administered.

The three-drug protocol including midazolam was used for the first time by the State of Oklahoma on April 29, 2014, in its execution of Clayton Lockett. After receiving all three drugs (including 100 milligrams of midazolam) and being declared unconscious, Mr. Lockett began to speak and move. The State then concealed Mr. Lockett from public view; he died thereafter. The State conducted an investigation into Mr. Lockett's execution, eventually concluding that an improper intravenous line had been the cause of the problem. Following that

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[5] Noxious stimuli are events that are "disconcerting to the brain. That can be everything from air hunger from rising carbon dioxide levels after vecuronium is given to the pain of the potassium chloride injection." J.A. vol. I 218 [hereinafter J.A.].

finding, the State adopted a new execution protocol, which includes the same three-drug combination used in the Lockett execution. The new protocol merely increases the dosage of midazolam from 100 milligrams to 500 milligrams. This minor change, however, is inadequate because researchers and medical practitioners have concluded that midazolam has no analgesic, or pain-relieving, qualities. As noted, moreover, midazolam has a ceiling effect—a dose beyond which any additional dosage does not produce any additional effect.[6]

Petitioners were among a group of twenty-one Oklahoma death-row inmates to file a 42 U.S.C. § 1983 complaint challenging the state's use of midazolam in executions. Petitioners sought a preliminary injunction to stay their executions until the district court could rule on the merits of their claims. After a three-day hearing, the district court denied their request, concluding that they had failed to demonstrate a likelihood of success on the merits of their claims. The Tenth Circuit affirmed. After denying Petitioners' application for stays of execution, this Court granted *certiorari*.

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[6] Medical literature describes midazolam as reaching "its maximal effect on brain activity after a dose of approximately 0.3 mg/kg." J.A. 233. For a 70-kilogram (or 154-pound) adult, then, the ceiling effect would occur at 21 milligrams.

In evaluating whether to grant a preliminary injunction, the district court heard testimony from Petitioners' experts about midazolam's characteristics and its ceiling effect, as well as its potential for causing agitation and combativeness. To rebut Petitioners' evidence regarding midazolam, Respondents presented only one expert: Dr. R. Lee Evans, who has not published a clinical study of drug effects in almost two decades. Dr. Evans testified that 500 milligrams of midazolam is sufficient to render any individual unconscious at a level sufficient to resist the noxious stimuli that may occur from the administration of the subsequent lethal drugs. Dr. Evans's conclusion was not supported by any reliable scientific data, and it lacked a basis in scientific principles or methodology; its deficiencies, moreover, were compounded by a key mathematical error. Dr. Evans read a "toxic" dose of midazolam to be 0.071 mg/kg, but his source actually shows a number of 71 mg/kg. J.A. 329. For a 70-kilogram (or 154-pound) adult, then, a "toxic" dose would be 4,970 milligrams, almost ten times the 500-milligram dose called for in Respondents' lethal injection protocol.

Dr. Evans even admitted that his conclusion about midazolam was not based on any scientific studies administering that dosage of the drug but, rather, was an extrapolation based on what he understood about fatalities allegedly caused by overdoses of midazolam. Dr. Evans also ignored critical evidence undermining his conclusion. As

defined by the scientific principles more fully described below, Dr. Evans's testimony was not scientifically rigorous, nor did he rely upon any scientific literature in formulating his opinions. For these reasons, Dr. Evans's improper scientific testimony failed *Daubert*, and the district court clearly erred in relying upon it to deny the motion for preliminary injunction.

ARGUMENT

I. SCIENTIFIC EVIDENCE MUST ADHERE TO SCIENTIFIC PRINCIPLES OF TESTING AND VALIDATION TO BE ADMISSIBLE.

In *Daubert*, this Court charged trial judges with ensuring "that any and all scientific testimony or evidence admitted is not only relevant, but reliable." *Daubert*, 509 U.S. at 589. To be admissible in court as "scientific knowledge," testimony must meet "a standard of evidentiary reliability." *Daubert*, 509 U.S. at 590. The Federal Rules of Evidence require not only that an expert witness be qualified by "knowledge, skill, experience, training or education" but also that the expert's testimony be "based upon sufficient facts or data" and "the product of reliable principles and methods." FED. R. EVID. 702. "[A] district judge asked to admit scientific evidence must determine whether the evidence is genuinely scientific, as distinct from being unscientific speculation offered by a genuine

scientist." *Rosen v. Ciba-Geigy Corp.*, 78 F.3d 316, 318 (7th Cir. 1996) (Posner, J.) (citing *Daubert*). This Court explained that the "focus, of course, must be solely on principles and methodology, not on the conclusions that they generate." *Daubert*, 509 U.S. at 595. "Such an approach is nothing more [and nothing less] than an effort to ensure that expert testimony does not enjoy the persuasive appeal of science without subjecting its propositions to the verification processes of science."[7]

More specifically, to meet the Court's standard of reliability, scientific evidence must "be derived by the scientific method" and "be supported by appropriate validation—*i.e.*, 'good grounds,' based on what is known." *Id.* at 590.[8] "[I]n order to qualify as 'scientific knowledge,' an inference or assertion must be derived by the scientific method." *Daubert*, 509 U.S. at 590. "The scientific method presumes that events occur in consistent patterns that can be

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[7] John William Strong, *Language and Logic in Expert Testimony: Limiting Expert Testimony by Restrictions of Function, Reliability, and Form*, 71 OR. L. REV. 349, 368 (1992).

[8] The *Daubert* standard is not intended to "banish novel applications of science from the courtroom, but it does demand that trial judges assure themselves that the underlying science is sound, so that the scientific expert is presenting scientific knowledge rather than speculating or dressing up unscientific opinion in the garb of scientific fact." FEDERAL JUDICIAL CENTER, REFERENCE GUIDE ON MEDICAL TESTIMONY 553 (2d ed. 2000).

understood through careful comparison and systematic study."[9] It is the "use of validated methods and care in following their protocols; the development of careful and adequate documentation; the avoidance of biases; and interpretation conducted within the constraints of what science will allow" that are the hallmarks of basic science.[10] Using these principles, theories are formulated to explain any number of events or occurrences. To gain credibility, these theories are then investigated repeatedly, shared through conferences and publications, and scrutinized by peers.[11]

One important consideration in this regard is whether the scientific knowledge "can be (and has been) tested" and whether it "has been subjected to peer review and publication." *Daubert*, 509 U.S. at

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[9] NATIONAL RESEARCH COUNCIL OF THE NATIONAL ACADEMIES, STRENGTHENING FORENSIC SCIENCE IN THE UNITED STATES: A PATH FORWARD 112 (2009).

[10] NATIONAL RESEARCH COUNCIL, at 113.

[11] NATIONAL RESEARCH COUNCIL, at 112-13. Scientific method, by its very nature, requires continuous testing and validation. "Scientists continually observe, test, and modify the body of knowledge. Rather than claiming absolute truth, science approaches truth either through breakthrough discoveries or incrementally, by testing theories repeatedly." *Id.* "Typically, experiments or observations must be conducted over a broad range of conditions before the roles of specific factors, patterns, or variables can be understood." *Id.*

593. Scientific literature is comprised of journals and other peer-reviewed materials intended to report empirical data and theories derived through the scientific method.[12] Inclusion in scientific literature involves a rigorous vetting process intended to inspire confidence in the content of such material.[13]

The *Daubert* analysis provides a method by which to assess all purportedly scientific evidence for reliability. Previously, courts employed divergent standards with predictably differing results, even for the same type of evidence. The danger of this undisciplined approach is evident in one particular example—the use of microscopic hair analysis, which *amicus* has studied diligently.[14] *Compare United*

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[12] National Commission on Forensic Science, *Views on Scientific Literature in Support of Forensic Science and Practice*, at 2 (adopted Jan. 30, 2015).

[13] For example, "[t]hroughout scientific investigations, the investigator must be as free from bias as possible, and practices are put in place to detect biases ... and to minimize their effects on conclusions." NATIONAL RESEARCH COUNCIL, at 112. For this reason, "[m]ethods that are specified in more detail ... will have greater credibility ... than those that rely more heavily on the judgments of the investigator." *Id.* at 114.

[14] "Before DNA testing was used in criminal trials, prosecutors throughout the country routinely relied on microscopic hair comparison analysis, often provided by the FBI, to link a criminal defendant to a crime." Innocence Project, *Innocence Project and NACDL Announce Historic Partnership with the FBI and Department of Justice on Microscopic Hair Analysis Cases* (July 18, 2013), available at http://www.innocence

States v. Cyphers, 553 F.2d 1064, 1071-73 (7th Cir. 1977) (allowing testimony that hairs recovered from crime scene were "microscopically like" hair samples taken from defendants because admissibility did not require "reasonable scientific certainty"), *with State v. Carlson*, 267 N.W.2d 170, 176 (Minn. 1978) (similar testimony was "improperly received" due to "the substantial unfairness to a defendant which may result from ill conceived techniques with which the trier of fact is not technically equipped to cope") (internal citation and quotation omitted).

Since *Cyphers* and *Carlson*, post-*Daubert* federal courts have become more sensitive to the dangers of unreliable expert opinions. As a result, courts have found that microscopic hair analysis lacks sufficient indicia of scientific reliability.[15] An important example is *Williamson v. Reynolds*, where the petitioner sought a writ of habeas corpus after being wrongfully convicted of capital murder and sentenced to death. 904 F. Supp. 1529 (E.D. Okla. 1995), *aff'd sub nom. Williamson v. Ward*, 110 F.3d

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project.org/news-events-exonerations/press-releases/innocence-project-and-nacdl-announce-historic-partnership-with-the-fbi-and-department-of-justice-on-microscopic-hair-analysis-cases.

[15] In 2009, the National Academy of Science also deemed the practice to be "highly unreliable." NATIONAL RESEARCH COUNCIL, at 161.

1508 (10th Cir. 1997).[16] Among the petitioner's claims was a challenge to evidence submitted by the government regarding a microscopic hair comparison conducted by criminologist Melvin Hett. At trial, Hett testified that he used a comparison microscope with magnifying capabilities of 50 to 400 times to compare samples of hair from the petitioner with hair found at the crime scene. Hett concluded that the samples "matched" based on a number of characteristics he observed. *Williamson v. Reynolds*, 904 F. Supp. at 1553-54.

On habeas review, the district court expounded upon the need for expert testimony to be based on scientific reliability, as opposed to subjective speculation. The court held that the hair-matching evidence was speculative because "[a]lthough the hair expert may have followed procedures accepted in the community of hair experts, the human hair comparison results were, nonetheless, *scientifically* unreliable." *Id.* at 1558 (emphasis added). Specifically, the court explained

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[16] While affirming the district court's granting of a new trial, the Tenth Circuit instructed that in a federal habeas challenge to a state court proceeding, review of the admission of evidence should be "under a due process/fundamental fairness standard." *Williamson v. Ward*, 110 F.3d at 1523. Nevertheless, that assessment also requires examining "the reliability of the evidence," *id.*, and the district court's analysis remains an excellent example of the reliability analysis mandated by *Daubert* before scientific evidence can be admitted.

that such testimony could not properly be introduced as scientific evidence because "there is no research to indicate with any certainty the probabilities that two hair samples are from the same individual" and "the weight the examiner gives to the presence or absence of a particular characteristic depends upon the examiner's subjective opinion" as opposed to objective standards. *Id.* at 1556-58.

Following the federal court's grant of habeas relief, DNA testing excluded Williamson as a suspect, another person was convicted of the crime, and Williamson's story of "wrongful conviction, imprisonment, and subsequent exoneration" were chronicled by author John Grisham in his 2006 book *The Innocent Man*. *Peterson v. Grisham*, 594 F.3d 723, 726 (10th Cir. 2010). Indeed, the failure of various courts to perform adequate gatekeeping in relation to hair comparison evidence has led to an unprecedented audit of thousands of hair comparison cases in a collaborative effort among the Innocence Project, the National Association for Criminal Defense Lawyers ("NACDL"), the FBI, and the Department of Justice.[17]

Unfortunately, notwithstanding the advances in science and guidance provided by this Court in *Daubert*, confusion abounds in the lower courts as to what actually constitutes reliable scientific evidence.

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[17] *See* Innocence Project, *supra* note 14.

Fortunately, the lower courts often get it right when they ask whether expert opinions have been derived through the scientific method and are supported by peer-reviewed literature. For example, in *Moore v. Ashland Chemical, Inc.*, the Fifth Circuit, sitting en banc, affirmed the exclusion of an expert's opinion on the cause of the plaintiff's illness, where that opinion was not well-grounded in the scientific method. 151 F.3d 269 (5th Cir. 1998) (en banc), *cert. denied*, 119 S. Ct. 1454 (1999). In *Moore*, the plaintiff claimed that a leak of Toluene solution in his truck caused him to develop reactive airways dysfunction syndrome ("RADS"), an asthmatic-type condition. The trial court rightfully refused to permit one of the plaintiff's medical witnesses, Dr. Daniel E. Jenkins, a pulmonary specialist, to give an opinion on the cause of the plaintiff's illness. *Id.* at 273. Although Dr. Jenkins was permitted to testify about the facts of his personal examination of the plaintiff, the court excluded his conclusion that the Toluene solution caused the plaintiff's RADS. *Id.* at 273-74.

As the court explained, under *Daubert*, Dr. Jenkins's opinion regarding the cause of the plaintiff's illness was not sufficiently reliable for a number of reasons. *Id.* at 277-79. First, he lacked experience actually treating patients who were exposed to Toluene solution. Nor did Dr. Jenkins rely on any medical literature purporting to establish a link between exposure to Toluene solution and the development of RADS. Additionally, Dr. Jenkins's

theory of causation was not supported by scientific principles: "Dr. Jenkins's theory had not been tested; the theory had not been subjected to peer review or publication; the potential rate of error had not been determined or applied; and the theory had not been generally accepted in the scientific community." *Id.* at 279. Consequently, the court found his opinion regarding causation to be "unscientific speculation offered by a genuine scientist" as opposed to "genuinely scientific" evidence. *Id.* at 278 (internal citation omitted).

As these and many other cases make clear, information or testimony offered as scientific evidence may be unreliable for a multitude of reasons. *See, e.g.*, *Henry v. St. Croix Alumina, LLC*, 572 F. App'x 114, 118 (3d Cir. 2014) (experts' opinions as to amount and toxicity of irritant escaping plant were not reliable because they "did not utilize a peer-reviewed methodology, subject to any known rate of error"); *Polski v. Quigley Corp.*, 538 F.3d 836, 840 (8th Cir. 2008) (district court properly excluded expert's testimony because his theory had not been tested at all); *Ruggiero v. Warner-Lambert Co.*, 424 F.3d 249, 254 (2d Cir. 2005) (expert's testimony about diagnosis was unreliable because it was not based on any studies and failed to rule out other possible causes); *Marsh v. W.R. Grace & Co.*, 80 F. App'x 883, 887 (4th Cir. 2003) (expert's testimony was unreliable because the theories underlying his conclusion had not been

subjected to peer review or publication, and failed to provide a means to verify his conclusion by ruling out alternative causes); *Alison v. McGhan Medical Corp.*, 184 F.3d 1300, 1313 (8th Cir. 1999) (expert's testimony was unreliable because it did not use proper scientific methodology, his theories had not been tested or subjected to peer review, and were not generally accepted by the scientific community); *Bradley v. Brown*, 42 F.3d 434, 438 (7th Cir. 1994) (testimony of experts unreliable where "the method leading to their conclusions was merely anecdotal").[18]

It is thus imperative that judges fulfill their gatekeeper role by screening scientific evidence to ensure that it is grounded in scientifically valid principles and methodology. Empirical testing, peer review and publication, the existence of known or potential error rates, and standards controlling the technique's operation are just some of the hallmarks

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[18] Comparative bullet-lead analysis, "a forensic test once thought capable of identifying unique bullets based on their chemical makeup," presents another relevant example of previously used scientific evidence that has, after investigation by the National Academy of Sciences, been found to be unreliable. In 2005, the FBI ceased offering such evidence, and as of January 2010, at least three convictions where bullet lead evidence was used had been overturned. Innocence Project, *Three Freed, and FBI Continues to Review Ballistic Cases* (Jan. 19, 2010), available at http://www.innocenceproject.org/news-events-exonerations/three-freed-and-fbi-continues-to-review-ballistic-cases.

of basic scientific method.[19] Adherence to these standards is critical in differentiating between reliable and unreliable scientific evidence.

II. THE DISTRICT COURT ABUSED ITS DISCRETION BY ADMITTING PATENTLY UNRELIABLE SCIENTIFIC TESTIMONY.

Given the importance of scientific testimony in our justice system, the courts' vital gatekeeping role under *Daubert* is "to ensure the reliability and relevancy" of that testimony. *Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137, 152 (1999). It is the court's responsibility to "make certain that an expert ... employs in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field." *Id.*; *see also Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 148 (1997) ("[W]hen law and science intersect, [the courts' gatekeeper] duties often must be exercised with special care.") (Breyer, J., concurring); *Jinro America Inc. v. Secure Investments, Inc.*, 266 F.3d 993, 1005 (9th Cir. 2001) ("[A]lthough the district judge has discretionary authority, reviewable for its abuse, to determine reliability in light of the particular facts and circumstances of the particular case, the *proper* exercise of that gatekeeping function is critically

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[19] FEDERAL JUDICIAL CENTER, at 12 (citing *Daubert*, 509 U.S. at 593-94).

important.") (emphasis added and internal quotations omitted) (citing *Kumho Tire*, 526 U.S. at 158, and *Daubert*, 509 U.S. at 590, 594-95).[20]

Under this Court's precedents, "a court of appeals is to apply an abuse-of-discretion standard when it 'review[s] a trial court's decision to admit or exclude expert testimony.'" *Kumho Tire*, 526 U.S. at 152 (citing *Joiner*, 522 U.S. at 138-39).[21] Although

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[20] Studies have suggested that *improper* performance of the courts' *Daubert* gatekeeper function is more rampant in criminal cases than civil cases. *See* David L. Faigman, *et al.*, *Applying* Daubert: *Criminal Cases*, 1 MOD. SCI. EVIDENCE § 1:35 (2014-15 ed.). In civil cases, the rate of exclusion of challenged expert evidence has risen from about 50% pre-*Daubert* to as high as 70% in the years post-*Daubert*. *Id.* But in criminal cases, "in federal district courts, defense challenges to government evidence succeeded less than 10% of the time." *Id.* While some differences between criminal and civil litigation—including the burdens and incentives of the parties—may contribute to that large disparity, commentators have opined that "if *Daubert* gatekeeping were rationally based on the quality of the underlying expert evidence, the exclusion rate pursuant to defense challenges would be higher than it is." *Id.*

[21] Trial courts must determine "whether particular expert testimony is reliable and will assist the trier of fact," as well as "whether the probative value of testimony is substantially outweighed by risks of prejudice, confusion or waste of time." *Joiner*, 522 U.S. at 520 (Breyer, J., concurring) (citing FRE 702 and FRE 403; internal quotations omitted). To the extent these findings require firsthand observation and subjective judgment, deference to the courtroom setting is appropriate. But "[t]he first and most significant *Daubert* factor is whether the

abuse-of-discretion is a relatively high standard, it is not a blank check allowing trial courts to admit unreliable scientific evidence, such as "opinion evidence that is connected to existing data only by the *ipse dixit* of the expert." *Joiner*, 522 U.S. at 146. Put differently, "it is not discretion to perform the function inadequately. Rather, it is discretion to choose among *reasonable* means of excluding expertise that is *fausse* and science that is junky." *Kumho Tire*, 526 U.S. at 159 (Scalia, J., joined by O'Connor and Thomas, JJ., concurring) (emphasis in original). When a trial court fails to require that an expert's "particular opinions [be] based on valid reasoning and reliable methodology" before admitting that expert's testimony, the court abuses its discretion. *Tauto v. Brown*, 85 F. App'x 674, 677 (10th Cir. 2003) (reversing and remanding for a new trial because district court abused its discretion in failing to perform its *Daubert* gatekeeper function properly); *see also Dodge v. Cotter Corp.*, 328 F.3d 1212, 1228-29 (10th Cir. 2003) (reversing when district court abused its discretion by declining to

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scientific theory has been subjected to the scientific method." *Bradley*, 42 F.3d at 438. Such objective factors as whether a scientific foundation was laid and the scientific method followed focus more on scientific truths. Thus, unlike weighing prejudice versus probative value, review of objective, scientific factors can be more reliably accomplished on appeal. Since objective scientific truths are equally available to appellate and trial judges, more robust review is both possible and appropriate.

review "full copies of all relevant studies upon which the experts relied").

Moreover, the trial court's gatekeeper function must focus on an examination of the expert's methodology, not just his qualifications. Even "[a] supremely qualified expert cannot waltz into the courtroom and render opinions unless those opinions are based upon some recognized scientific method and are reliable and relevant under the test set forth by the Supreme Court in *Daubert*." *Clark v. Takata Corp.*, 192 F.3d 750, 759 n.5 (7th Cir. 1999). In examining the putative expert's reasoning and methodology, the trial court must "determine whether it is scientifically valid and applicable to a particular set of facts." *Goebel v. Denver & Rio Grande Western R.R. Co.*, 215 F.3d 1083, 1087 (10th Cir. 2000); *id.* at 1088 ("It is axiomatic that an expert, no matter how good his credentials, is not permitted to speculate."). Scientific validity depends on the factors discussed *supra*, Argument Part I.

In this case, the trial court abused its discretion when it failed to properly exercise its gatekeeper role by relying on expert testimony lacking in scientific validity. The trial court relied solely on the testimony of Respondents' single expert, Dr. Evans, in determining that 500 milligrams of midazolam "would make it a virtual certainty that any individual will be at a sufficient level of unconsciousness to resist the noxious stimuli which

could occur from the application of the second and third drugs." J.A. 77. Dr. Evans's opinion, however, was admittedly based on "extrapolation" and "assumption." Tr. of Prelim. Inj. Hr'g at 667-68, *Warner v. Gross*, No. 5:14-cv-665 (W.D. Okla. Dec. 17-19, 2014) [hereinafter Tr.].[22] He conceded that he was "essentially extrapolating this piece and saying there is a linear effect in terms of administration of the drug." *Id.*

But a key indicator of the reliability of expert testimony is "[w]hether the expert has *unjustifiably extrapolated* from an accepted premise to an unfounded conclusion."[23] In such circumstances a trial court "may conclude that there is simply too great an analytical gap between the data and the opinion proffered." *Joiner*, 522 U.S. at 146. Dr. Evans based his opinion on uncited, unsubstantiated anecdotes involving unknown dosages of midazolam.

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[22] "The burden of establishing qualification, reliability, and helpfulness rests on the proponent of the expert opinion, whether the proponent is the plaintiff or the defendant in a civil suit, or the government or the accused in a criminal case." *United States v. Frazier*, 387 F.3d 1244, 1260 (11th Cir. 2004) (en banc). Given the unsatisfactory reasoning propounded by Dr. Evans as described herein, the lower court's ruling that Respondents had carried their burden of establishing the admissibility of his testimony was incorrect.

[23] Advisory Committee Notes, FED. R. EVID. 702 (2000) (emphasis added).

Tr. 667-68.[24] In contrast, the well-documented executions of Clayton Lockett and Joseph Wood provide objective evidence that is contrary to Dr. Evans's extrapolations. Even large amounts of midazolam demonstrably did not render those two prisoners comatose. J.A. 392-94; J.A. 176-77. In particular, Mr. Wood received a total of 750 milligrams of midazolam, 250 milligrams above what Dr. Evans opined should be more than sufficient to render someone comatose, or even kill him. J.A. 176-77.[25] Dr. Evans's anecdotes of overdoses also failed to address whether midazolam reliably induces a sustained comatose state prior to death, a key issue in this case. Such unjustifiable extrapolation by Dr. Evans reflects exactly the type of "analytical gap" that is a hallmark of scientifically unreliable evidence.

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[24] Without dosage data, it is unclear how Dr. Evans could have established his assumption of a "linear effect," particularly in light of the observed "ceiling effect" of midazolam described in the scientific literature. J.A. 172, 206, 208-09; Tr. 343; Tr. 664. Admitting Dr. Evans's "speculative conclusions about [a drug's] toxicity from questionable principles of pharmacology" constitutes reversible error. *McClain v. Metabolife Intern., Inc.*, 401 F.3d 1233, 1240 (11th Cir. 2005).

[25] As illustrated by these horrifically botched executions, Dr. Evans's opinion also suffers from having "no known potential rate of error." *Vargas v. Lee*, 317 F.3d 498, 501 (5th Cir. 2003). The admission of scientific evidence that "has not been verified or generally accepted, [and] also has no known potential rate of error ... constitute[s] an abuse of discretion." *Id.*

Dr. Evans's opinion testimony also suffers from additional scientific defects. Rather than relying on extensive testing and peer-reviewed sources as the scientific method requires, *see supra*, Argument Part I, Dr. Evans instead consulted drugs.com, a reference website ("really a tertiary resource," J.A. 325) targeted for mass consumption, and a Material Safety Data Sheet ("MSDS") about midazolam. The MSDS is a document required by the Occupational Safety and Health Administration ("OSHA") designed to alert workers about potential dangers of chemicals. 29 C.F.R. § 1910.1200(g). Drugs.com warns users that it "*is not intended for medical advice, diagnosis or treatment.*" J.A. 276. The MSDS warns that the information it provides is "*without any warranty, express or implied, regarding its correctness.*" J.A. 279. As such, neither is a valid source of scientifically reliable information. In addition, Dr. Evans committed a material miscalculation while relying on what the MSDS suggested could be a toxic dose of midazolam: he used a number in his calculations that was off by a factor of one thousand, rendering Respondents' planned 500-milligram dose a mere tenth of what a correctly calculated toxic amount would be under the MSDS. J.A. 329.[26] Where an expert "infers

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[26] Dr. Evans read a "toxic" dose of midazolam to be 0.071 mg/kg, but the MSDS actually conveys a number of 71 mg/kg. J.A. 329. For a 70-kilogram (or 154-pound) adult, then, a "toxic" dose would be 4,970 milligrams, almost ten times the 500-

conclusions from studies and reports that the papers do not authorize, and unjustifiably relies on government public health reports ... to establish medical causation," his opinions "lack the indicia of reliability necessary to survive a *Daubert* inquiry and challenge under Rule 702." *McClain*, 401 F.3d at 1240 (reversing where trial court erroneously admitted expert testimony); *Moore*, 151 F.3d 269 (clinical doctor's opinion testimony properly excluded where it was not sufficiently grounded in scientific methodology). Given these clear errors, the trial court's decision to rely on Respondents' expert testimony was an abuse of discretion.

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milligram dose that Respondents' lethal injection protocol calls for.

CONCLUSION

The judgment of the Tenth Circuit Court of Appeals should be reversed.

Respectfully submitted,

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Supreme Court of the United States

RICHARD E. GLOSSIP, *et al.*,

Petitioners,

v.

KEVIN J. GROSS, *et al.*,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF FOR THE LOUIS STEIN CENTER FOR LAW AND ETHICS AT FORDHAM UNIVERSITY SCHOOL OF LAW AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF *AMICUS CURIAE*	1
INTRODUCTION AND SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. HISTORICALLY, PUBLIC AWARENESS OF THE UNNECESSARY RISK OF PAIN AND SUFFERING OF A PRIOR EXECUTION METHOD HAS CAUSED STATE LEGISLATURES TO ADOPT A NEW METHOD	4
II. IN SWITCHING TO LETHAL INJECTION, LEGISLATURES DELEGATED IMPLEMENTATION OF THE METHOD TO PRISON OFFICIALS WHO ADOPTED PROCEDURES WITHOUT MEDICAL STUDY OR MEANINGFUL ANALYSIS.	12
A. The Development Of Lethal Injection Protocols Lacked Any Reasoned Consideration	12
1. Oklahoma's Adoption Of Lethal Injection	12
2. Widespread Adoption Of The Three-Drug Protocol	16

TABLE OF CONTENTS—Continued

Page

B. State Prison Officials Continue To Follow The Same Historical Pattern In Relying Upon Insufficient Scientific And Medical Study In Modifying Lethal Injection Protocols 18

1. The Use Of A One-Drug Protocol .. 19

2. A Shift In The Drugs Used 22

III. JUDICIAL SCRUTINY OF PRISON OFFICIALS' ADMINISTRATION OF LETHAL INJECTION IS NECESSARY TO ENSURE COMPLIANCE WITH THE EIGHTH AMENDMENT 26

A. Judicial Examination Of Modifications To Protocols Is Necessary Because The Actions Of Prison Officials Are Not Subject To Public Scrutiny And Oversight 26

B. The Delegation Of Lethal Injection Procedures To Prison Officials Permits Corrective Revision Of Protocols To Ensure Compliance With The Eighth Amendment 30

CONCLUSION 33

TABLE OF AUTHORITIES

CASES	Page(s)
Abdur'Rahman v. Bredesen, 181 S.W.3d 292 (Tenn. 2005)	32
Arthur v. Thomas, No. 2:11-cv-438-WKW, 2015 WL 224738 (M.D. Ala. Jan. 15, 2015)	24
Baze v. Rees, 553 U.S. 35 (2008)	1, 2, 13, 14, 15, 16, 17, 21, 27, 28, 29, 31
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Bryan v. Moore, 528 U.S. 1133 (2000)	1, 8
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519 U.S. 918 (1996) 11

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147 F.3d 1158 (9th Cir. 1998) 11

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710 F.2d 1048 (5th Cir. 1983) 10

Gregg v. Georgia,
428 U.S. 153 (1976) 12

Harbison v. Little,
511 F. Supp. 2d 872 (M.D. Tenn. 2007),
rev'd, 571 F.3d 531 (6th Cir. 2009) 20, 28

Hill v. McDonough,
547 U.S. 573 (2006) 31, 32

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738 S.E.2d 56 (Ga. 2013)..... 32

Hobbs v. Jones,
412 S.W. 3d 844 (Ark. 2012) 16

Jones v. Bock,
549 U.S. 199 (2007) 32

In re Kemmler,
136 U.S. 436 (1890) 5, 7, 9

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741 F.3d 888 (8th Cir. 2014),
reh'g denied, 741 F.3d 903 (8th Cir. 2014),
cert. denied, 134 S.Ct. 1790 (2014) 23

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237 U.S. 180 (1915) 6

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Nos. 3:06-cv-00219, 3:06-cv-926, 2010 WL
3751757 (N.D. Cal. Sept. 24, 2010)..... 19

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415 F. Supp. 2d 1037 (N.D. Cal. 2006) 19

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132 So.3d 176 (Fla. 2013), *cert. denied*, 134
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541 U.S. 637 (2004) 31

In re Ohio Execution Protocol Litig.,
994 F. Supp. 2d 906 (S.D. Ohio 2014)..... 24

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627 F.3d 1336 (10th Cir. 2010) 23, 27

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No. 04CR065940, 2008 WL 2784679
(Ohio Ct. Com. Pl. June 10, 2008) 20, 21

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No. 2:07-cv-04129, 2006 WL 1779035
(W.D. Mo. June 26, 2006),
rev'd 487 F.3d 1072 (8th Cir. 2007) 28

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776 F.3d 721 (10th Cir. 2015) 24, 25

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(5th Cir. 2013), *cert. denied sub nom.*,
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99 U.S. 130 (1878) 5

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18 U.S.C. § 3596 16

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INTEREST OF *AMICUS CURIAE* [1]

The Louis Stein Center for Law and Ethics is based at Fordham University School of Law and sponsors programs, develops publications, supports scholarship on contemporary issues of law and ethics, and encourages professional and public institutions to integrate moral perspectives into their work. Over the past decade, the Stein Center and affiliated Fordham Law faculty have examined the ethical dimensions of the administration of criminal justice, including the ethical and historical dimensions of the death penalty and execution methods. The Stein Center has submitted *amicus* briefs in two prior cases in which the Court has been asked to examine methods of execution: *Bryan v. Moore*, 528 U.S. 960 (1999), *cert. dismissed as improvidently granted*, 528 U.S. 1133 (2000), which the Court had granted to consider whether electrocution violated the Eighth Amendment's Cruel and Unusual Punishments Clause, and *Baze v. Rees*, 553 U.S. 35 (2008), in which the Court examined the constitutionality of lethal injection as implemented in Kentucky and in which the Court cited the Stein Center brief.

Implementation of lethal injection as a method of execution implicates ethical questions important to the Stein Center. The evolution of execution methods in the United States generally suggests a public consensus opposed to the infliction of severe pain and

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[1] Pursuant to Rule 37.3, the parties have consented to the filing of this brief. Letters of consent have been filed with the Clerk. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to its preparation or submission.

suffering in the course of executing individuals sentenced to death. At the same time, it is doubtful whether in practice execution methods achieve that goal. In the context of lethal injection, there are serious concerns whether prison officials, legislators, and courts have responded to the risks associated with the implementation of lethal injection in an ethical manner.

INTRODUCTION AND SUMMARY OF ARGUMENT

The landscape of the implementation of lethal injection has changed greatly in the seven years since this Court's decision in *Baze v. Rees*, 553 U.S. 35 (2008). During this time, States have moved away from the three-drug protocol synonymous with lethal injection since its adoption—a protocol to which States adhered for decades. Such changes have been implemented not by state legislatures, but by prison officials charged with carrying out lethal injection executions. This brief analyzes how the history of execution methods informs the Court's analysis of Petitioners' challenge to Oklahoma's most recent revision to its lethal injection protocol.

(1) As the Court recognized in *Baze*, the history of execution methods in the United States demonstrates that States moved toward new methods in an effort to execute inmates in a humane manner free from unnecessary pain. Historically, laws switching execution methods came about as society became more aware of the risks associated with a certain execution method, *e.g.*, when electrocutions produced horrific scenes of burning flesh, or when lethal gas resulted in the slow asphyxiation in the gas chamber. Such legislative action meant this Court rarely had occasion

to examine the constitutionality of an execution method under the Eighth Amendment.

(2) When States adopted lethal injection as an execution method, the great majority of States left statutes purposefully vague as to the lethal injection procedure. Oklahoma developed a three-drug lethal injection protocol in 1977. That protocol, which nearly every lethal injection State and the federal government subsequently copied, lacked adequate medical or scientific basis. Notwithstanding the Court's decision in *Baze* approving the three-drug protocol, States have moved away from the original three-drug protocol in recent years. Such changes resulted not from deliberate evaluation of the merits of modified protocols or from legislative enactment, but from court decree or practical considerations.

(3) Because States delegate the details of lethal injection executions to prison officials, protocols are not subject to public scrutiny and oversight. On the one hand, this system leaves departments of corrections with the ability to create and implement alternatives to existing procedures. On the other hand, prison officials have continued to adopt protocols lacking sufficient scientific or medical basis. The responsibility for ensuring that executions do not risk unnecessary cruelty or lingering death thus lies with the courts. Judicial review of such protocols is necessary to ensure that administration of lethal injection comports with the Eighth Amendment.

ARGUMENT

I. HISTORICALLY, PUBLIC AWARENESS OF THE UNNECESSARY RISK OF PAIN AND SUFFERING OF A PRIOR EXECUTION METHOD HAS CAUSED STATE LEGISLATURES TO ADOPT A NEW METHOD.

As is well documented, the federal government and every State that has the death penalty employ lethal injection as the method of execution. Prior to lethal injection, States switched methods when pre-existing methods were shown in practice to embody a high risk of painful or lingering death. In large part, the coordinated move from one execution method to another took place by legislative dictate rather than judicial decree. *See generally* Deborah W. Denno, *When Legislatures Delegate Death: The Troubling Paradox Behind State Uses of Electrocution and Lethal Injection and What it Says About Us*, 63 OHIO ST. L.J. 63 (2002). With the exception of a few States that permitted use of the firing squad, the general historical trend in the United States led to the transition from hanging to electrocution, which gave way briefly to reliance on the gas chamber, before settling on lethal injection.

Hanging. In the mid-nineteenth century, States typically favored the use of hanging as the method of execution, while three States allowed for execution by firing squad.[2] By 1853, hanging had become "the

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[2] No State currently relies on the firing squad as the primary method of execution and only Utah and Oklahoma still authorize the firing squad as an alternative to lethal injection under some limited circumstances. *See* Tracy L. Snell, *Capital Punishment, 2013 – Statistical Tables*, Bureau of Justice Statistics Bull. No.

nearly universal form of execution in the United States and 48 States imposed death by this method." *Campbell v. Wood*, 511 U.S. 1119, 114 S. Ct. 2125, 2125 (1994) (Blackmun, J., dissenting from denial of *certiorari*) (internal citation and quotation marks omitted). The method required "no equipment beyond a rope and a high structure," and "no expertise beyond the ability to tie a knot." STUART BANNER, THE DEATH PENALTY: AN AMERICAN HISTORY 44 (2003). Despite the seeming simplicity of the method, hanging had begun to fall out of favor by the late 1800s, after the public witnessed gruesomely botched hangings that involved decapitations and slow strangulations.[3] Societal awareness of the "[b]ungled hangings [that] often caused intense pain and on occasion failed to kill" led legislatures to search for a more humane method of execution. BANNER, *supra*, at 175; *In re Kemmler*, 136 U.S. 436, 444 (1890) (describing the quest to determine "'whether the science of the present day'" could find a "less barbarous manner" of execution than hanging) (quotation marks omitted).

By 1994, only two States employed hanging as an execution method. *See Campbell v. Wood*, 18 F.3d 662,

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NCJ 248448, U.S. BUREAU OF JUSTICE STATISTICS, at 4 & 7 tbl. 2 (Dec. 19, 2014), *available at* http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5156; Christopher Q. Cutler, *Nothing Less than the Dignity of Man: Evolving Standards, Botched Executions and Utah's Controversial Use of the Firing Squad*, 50 CLEV. ST. L. REV. 335, 337 (2003) (noting the historical use of the firing squad but that only a few States had statutes permitting its use). In *Wilkerson v. Utah*, 99 U.S. 130 (1878), the Court held that death by firing squad did not rank among the "cruel and unusual punishments" banned by the Eighth Amendment, but the Court did so without "defin[ing] with exactness the extent of the constitutional provision which provides that cruel and unusual punishments shall not be inflicted." 99 U.S. at 134-36.

[3] BANNER, *supra*, at 172-75.

app. B at 726-29 (9th Cir. 1994) (en banc). In that year, this Court declined to review a decision of the United States Court of Appeals for the Ninth Circuit that held that the State of Washington's use of hanging as a method of execution did not violate the Eighth Amendment. *Campbell v. Wood*, 511 U.S. 1119 (1994). In reaching this conclusion, the Ninth Circuit relied upon the specific protocol Washington had adopted, which was based on scientific study and expert analysis undertaken to minimize the risk of an inhumane death by hanging. *Campbell*, 18 F. 3d at 687. In spite of the judicial position on hanging, greater public awareness and deliberation as to the continuing risk of unnecessary pain and brutality of hanging caused Washington State to adopt lethal injection as its default method of execution in 1996.[4]

Electrocution. Although Washington was slow to move away from hanging (a pace likely explained in part by the fact that Washington did not execute anyone for three decades preceding 1993),[5] many States had moved to a new method of execution at the turn of the century. By 1915, twelve States had switched from hanging to electrocution, in reliance upon the "belief that electrocution is less painful and more humane than hanging." *Malloy v. South Carolina*, 237 U.S. 180, 185 (1915). Throughout the early part of the twentieth century, the vast majority of States turned to the electric chair as the preferred method of execution. *See Campbell*, 18 F.3d at app. B 726-29; Denno, 63 OHIO ST. L.J. at 130 tbl. 2.

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[4] Wash. Rev. Code Ann. § 10.95.180(1) (requiring lethal injection unless the inmate elects hanging); *see also* Denno, 63 OHIO ST. L.J. at app. 2 at 205-06.

[5] *Persons Executed Since 1904 in Washington State*, WASH. STATE DEP'T OF CORRECTIONS, http://www.doc.wa.gov/offenderinfo/capitalpunishment/executedlist.asp (last visited Mar. 9, 2015).

The change from hanging to electrocution began in New York in the late 1800s, when members of the New York legislature began investigating the use of electricity in executions. BANNER, *supra*, at 178; *In re Kemmler*, 136 U.S. at 444. At that time, the electric chair was viewed as a modern method of execution and, through the use of technology, able to cause a quick and painless death. *See* NEW YORK (STATE) COMMISSION ON CAPITAL PUNISHMENT, REPORT OF THE COMMISSION TO INVESTIGATE AND REPORT THE MOST HUMANE AND PRACTICAL METHOD OF CARRYING INTO EFFECT THE SENTENCE OF DEATH IN CAPITAL CASES, 80 (1888).

New York adopted electrocution on the premise that it presented a more humane method of execution even though no inmate had ever been executed by the electric chair and thus New York lacked any evidence of how the method would work in practice. Denno, 63 OHIO ST. L.J. at 71-74; *see generally* Deborah W. Denno, *Is Electrocution An Unconstitutional Method of Execution? The Engineering of Death Over the Century*, 35 WM. & MARY L. REV. 551 (1994). Indeed, the electric chair did not even exist at the time New York switched to the method and "[p]rison officials . . faced the task of acquiring machinery that had not yet been designed." BANNER, *supra*, at 181; *see id.* at 182.

In 1890, this Court permitted the first execution by electric chair to proceed, relying on New York's expressed motivation of finding a more humane method of execution. *In re Kemmler*, 136 U.S. at 447-49. New York's execution of Kemmler in 1890 was plagued with serious problems, but that did not deter other States from adopting the method. BANNER, *supra*, at 186, 189; Denno, 63 OHIO ST. L.J. at 71-74 & n.55. By 1930, more than half of the then-active death

penalty States employed the electric chair. *See* RAYMOND PATERNOSTER, CAPITAL PUNISHMENT IN AMERICA 15 (1991); Denno, 63 OHIO ST. L.J. at 130 tbl. 2. As States continued to copy New York's method, "prison officials from the later states to adopt the chair traveled to the earlier states to learn how to construct and operate the necessary equipment." BANNER, *supra*, at 190. But the problems of New York's first-time use of the electric chair persisted, with widely reported accounts of gruesomely botched electrocutions over the years. *See* Deborah W. Denno, *Getting to Death: Are Executions Constitutional?*, 82 IOWA L. REV. 319, app. 2.A at 413 (1997) (describing examples of botched executions); BANNER, *supra*, at 192-193.

Following a particularly gruesome electrocution in Florida, this Court agreed to examine the constitutionality of electrocution in the State. *See Bryan v. Moore*, 528 U.S. 960 (1999). By that time, public awareness of the risk that electrocutions would cause unnecessary pain and lingering death had reached a high point.[6] In early 2000, the Florida legislature altered its execution method to permit an inmate to choose between electrocution and lethal injection. *See* Fla. Stat. Ann. § 922.105; 2000 Fla. Sess. Law Serv. Ch. 2000-2 (West). As a result, the Court dismissed the writ as improvidently granted. *Bryan v. Moore*, 528 U.S. 1133 (2000) (dismissing writ in light of "recent amendments" to the Florida statute).

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[6] *See* Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled the Death Penalty*, 76 FORDHAM L. REV. 49, 63 (2007) (describing the 1999 botched execution of Allen Lee Davis, who suffered deep burns and bleeding, color photographs of which were viewed by millions of people on the Florida Supreme Court's website); Denno, 63 OHIO ST. L.J. at 78-79.

In the following years, two state courts ruled electrocution unconstitutional under state constitutions. In 2001, Georgia held electrocution unconstitutional, explaining "whether a particular punishment is cruel and unusual is not a static concept, but instead changes in recognition of the evolving standards of decency that mark the progress of a maturing society." *Dawson v. State*, 554 S.E.2d 137, 139 (Ga. 2001) (internal quotation marks omitted). The Georgia legislature had abolished electrocution as a method of execution for capital offenses committed after May 1, 2000, "reflect[ing] societal consensus that the 'science of the present day' has provided a less painful, less barbarous means for taking the life of condemned prisoners." *Id.* at 144 (quoting *In re Kemmler*, 136 U.S. at 444). The Nebraska Supreme Court held electrocution unconstitutional under the Nebraska State Constitution in 2008, reasoning that "[e]lectrocution's proven history of burning and charring bodies is inconsistent with both the concepts of evolving standards of decency and the dignity of man." *State v. Mata*, 745 N.W.2d 229, 278 (Neb. 2008). The Nebraska Supreme Court further explained that States that already had abolished electrocution through legislative process "have recognized that early assumptions about an instantaneous and painless death were simply incorrect and that there are more humane methods of carrying out the death penalty." *Id.*

Lethal Gas. Not all States initially turned to electrocution as an alternative to hanging, however. Early problems with electrocution together with the continued repugnant nature of hangings caused some States to experiment with the gas chamber. Nevada, which had never adopted electrocution, was the first State to authorize lethal gas in 1921. Denno, 63 OHIO

ST. L.J. at 83. At the time, Nevada's deputy attorney general persuaded two state legislators that the method would be more humane than hanging or the firing squad. BANNER, *supra*, at 196. "Within a week, apparently without any debate in either house of the legislature, both houses passed a bill providing for execution by lethal gas." *Id.* The legislature explained that the switch to lethal gas "sought to provide a method of inflicting the death penalty in the most humane manner known to modern science." *State v. Gee Jon*, 211 P. 676, 682 (Nev. 1923). By 1955, ten additional States had adopted lethal gas. Denno, 63 OHIO ST. L.J. at 83.

Nevada initially sought to rely on lethal gas because it was the method used in the relatively peaceful killings of animals. *See Gee Jon*, 211 P at 681. But, again, prison officials were tasked with figuring out the details of exactly how to carry out the method on human beings. BANNER, *supra*, at 197. As with prior execution methods, the first lethal gas execution did not go as planned and the hydrocyanic acid prison officials had chosen to use pooled on the floor of the gas chamber. *Id.* at 197-98. Over time, it became clear that inmates did not die peacefully by breathing in lethal gas while sleeping. Death lingered and inmates often urinated on themselves, moaned, twitched, and painfully convulsed for minutes before finally dying.[7] In addition, the gas chamber carried with it lasting association with the abhorrent mass killings in Nazi Germany. Allen Huang, *Hanging, Cyanide Gas, and the Evolving Standards of Decency: The Ninth Circuit's Misapplication of the Cruel and Unusual*

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[7] *See, e.g.*, *Gray v. Lucas*, 710 F.2d 1048, 1058-59 (5th Cir. 1983); *see also* Denno, 82 IOWA L. REV. at app. 2.B at 425.

Clause of the Eighth Amendment, 74 OR. L. REV. 995, 1007-08 (1995). The gas chamber fell out of favor.

In 1996, the Ninth Circuit ruled that execution by lethal gas under California's protocol constituted cruel and unusual punishment in violation of the Eighth Amendment and deemed the method unconstitutional. *Fierro v. Gomez*, 77 F.3d 301 (9th Cir. 1996), *cert. granted, judgment vacated*, 519 U.S. 918 (1996). The Ninth Circuit cited to the district court's findings that the evidence indicated inmates would experience extreme pain. *Id.* at 308-09. This Court avoided consideration of the constitutionality of the method when California (which allowed for a choice between lethal gas and lethal injection) amended its method of execution statute to set lethal injection as the default method unless the inmate chose lethal gas; the Ninth Circuit agreed on remand that the inmate no longer had standing to challenge the constitutionality of California's method of execution. *See Fierro v. Terhune*, 147 F.3d 1158, 1160 (9th Cir. 1998). In *Stewart v. LaGrand*, 526 U.S. 115 (1999), the Court held that a death row inmate had waived his claim that the Eighth Amendment prohibited his execution by lethal gas because the inmate specifically had chosen to be executed by lethal gas rather than lethal injection. 526 U.S. at 118-19.

II. IN SWITCHING TO LETHAL INJECTION, LEGISLATURES DELEGATED IMPLEMENTATION OF THE METHOD TO PRISON OFFICIALS WHO ADOPTED PROCEDURES WITHOUT MEDICAL STUDY OR MEANINGFUL ANALYSIS.

Public scrutiny of methods of execution intensified in the 1970s following the end of a nine-year execution hiatus while this Court considered the constitutionality of the death penalty. At that time, States turned to lethal injection, with Oklahoma leading the way. While Oklahoma touted the humaneness of the method, no evidence existed to support this conclusion. Oklahoma delegated the actual details of implementing the method to its department of corrections, which devised a three-drug protocol. States and the federal government followed suit in adopting lethal injection as a method of execution, in delegating responsibility for the development of specific protocols to prison officials, and in utilizing the same three-drug protocol. While the original three-drug protocol was commonplace for decades, more States have modified the drugs used in their execution protocols in the past seven years than at any point since the method's adoption.

A. The Development Of Lethal Injection Protocols Lacked Any Reasoned Consideration.

1. Oklahoma's Adoption Of Lethal Injection

As this Court has recognized, "state legislatures began responding to public calls to reexamine electrocution as a means of ensuring a humane death" following the Court's decision in *Gregg v. Georgia*, 428

U.S. 153 (1976). *Baze*, 553 U.S. at 41-42 (citing BANNER, *supra*, at 192-93, 296-97). Oklahoma, facing the need to refurbish its rotting electric chair, turned to lethal injection.[8] Oklahoma introduced the first lethal injection bill in 1977. *Baze*, 553 U.S. at 41-42; BANNER, *supra*, at 297; *Beardslee v. Woodford*, 395 F.3d 1064, 1073 (9th Cir. 2005). Two Oklahoma state legislators, State Representative Bill Wiseman and State Senator Bill Dawson, spearheaded the move toward lethal injection, driven by the inhumanity of electrocution and the costs associated with it.[9]

Because the Oklahoma Medical Association refused to assist with devising the new method of execution, Wiseman and Dawson consulted with A. Jay Chapman, Oklahoma's chief medical examiner. Deborah W. Denno, *The Lethal Injection Quandary: How Medicine Has Dismantled The Death Penalty*, 76 FORDHAM L. REV. 49, 65-66 (2007). Chapman agreed to assist the legislators even though he admitted he "'was an expert in dead bodies but not an expert in getting them that way.'" *Id.* at 66. Chapman quickly proposed use of an intravenous drip of "an ultra-short-acting barbiturate," which would cause unconsciousness, "in combination with a chemical paralytic," to paralyze

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[8] BANNER, *supra*, at 296. Oklahoma had adopted lethal gas as an execution method in 1951, but provided that electrocution would be used until the State could build a gas chamber, which it never did. *See* Denno, 63 OHIO ST. L.J. at app. 2 at 201 n.121. Construction of the gas chamber was estimated to cost at least $250,000 and fixing the State's electric chair was estimated to cost $50,000. Denno, 76 FORDHAM L. REV. at 71.

[9] *See* Denno, 76 FORDHAM L. REV. at 65-66, 71; Tim Barker, *Author of Lethal Injection Bill Recalls His Motive*, TULSA WORLD, Sept. 7, 1990, at A1, *available at* http://www.tulsaworld.com/archives/author-of-lethal-injection-bill-recalls-his-motive/article_90c3f8c3-22c5-5cd7-8d0c-42fb17378968.html.

the body's muscles. *Id.* at 66-67; *see also* William J. Wiseman, *Confessions of a Former Legislator*, CHRISTIAN CENTURY, June 20-27, 2001, at 6. According to Chapman, he specifically suggested to the legislators certain drugs for use: sodium thiopental as the ultra-short-acting barbiturate and chloral hydrate as the paralytic agent. Denno, 76 FORDHAM L. REV. at 67.

Dawson also sought input from Stanley Deutsch, the head of the Oklahoma Medical School's Anesthesiology Department, in a single phone call. *Id.* at 67-68; *see also Baze*, 553 U.S. at 42. After the call, Deutsch sent a letter recommending two types of drugs: an "ultra short acting barbiturate" and a "neuromuscular blocking drug." Denno, 76 FORDHAM L. REV. at 67.

The proposed bill in the Oklahoma legislature did not include specific drugs or doses based on the input of either Chapman or Deutsch. *Id.* No historical evidence suggests any further consultation with doctors or scientists, nor any study or consideration of any of available evidence concerning the risks and dangers of lethal injection. *Id.* at 65, 70.

The Oklahoma lethal injection bill introduced in early 1977 tracked Chapman's early formulation. An Act Relating to Criminal Procedure; Amending 22 O.S. 1971, Section 1014; and Specifying the Manner of Inflicting Punishment of Death; and Making Provisions Separable, S.B. 10, 36th Leg., 1st Sess. (Okla. 1977). The bill passed, and was signed into law on May 10, 1977, making Oklahoma the first state to authorize execution by lethal injection. Okla. Stat. Ann. tit. 22, § 1014.

The language included in Oklahoma's statute, however, was intentionally vague and delegated to prison officials authority to determine how to carry out

lethal injections. *Id.* Corrections officials had the responsibility for determining what drugs to use, what dosage to give, and who would administer the drugs and how. *See* Denno, 63 OHIO ST. L.J. at 68-69. Despite his admitted lack of expertise, Chapman again played a key role in assisting officials in developing the details of a lethal injection procedure. Denno, 76 FORDHAM L. REV. at 73-75. In light of his role as the medical examiner, it was perhaps unsurprising that Chapman was unconcerned with whether the specific protocol would inflict pain and suffering. Rather, when asked for the rationale behind his ultimate recommendation of specific drugs, he ridiculed the idea that "we should worry that these horses' patoots should have a bit of pain, awareness of anything." *Id.* at 74 n.151.

During Chapman's consultation with the department of corrections behind the scenes, the third drug, potassium chloride, was added to the two-drug combination. *Id.* at 74. Potassium chloride works in humans to stop the heart, and if an inmate is not sufficiently anesthetized before receiving the drug, it is undisputed that it will cause "a conscious inmate to suffer excruciating pain." *Baze*, 553 U.S. at 113 (Ginsburg, J., dissenting). Moreover, the second drug—the paralytic agent—would mask the expression of any pain. *See id.* at 71 (Stevens, J., concurring in the judgment); Denno, 76 FORDHAM L. REV. at 55-56; Eric Berger, *Lethal Injection Secrecy and Eighth Amendment Due Process*, 55 B.C.L. REV. 1367, 1377 (2014). In selecting these drugs at the time, prison officials in Oklahoma stated that "if and when they have to use the injection law, new and better drugs may be available." Deborah W. Denno, *Lethal Injection Chaos Post-Baze*, 102 GEO. L.J. 1331, 1357-60 (2014) (emphasis omitted).

2. *Widespread Adoption Of The Three-Drug Protocol*

Beginning immediately after Oklahoma adopted lethal injection, other States switched to the method, before the method ever had been used in an execution. *Baze*, 553 U.S. at 75 (Stevens, J., concurring in the judgment). Texas adopted lethal injection the very next day. Denno, 76 FORDHAM L. REV. at 78. By 1982, the year in which Texas conducted the first lethal injection execution, six States had enacted lethal injection statutes. Denno, 102 GEO. L.J. at 1341 cht. 1. Another fifteen States adopted lethal injection from 1983 to 1988, with seven States doing so in 1983. *Id.* That progression continued, with twelve States switching to lethal injection from 1994 to 2002. *Id.*; *see also* Denno, 82 IOWA L. REV. at 408 tbl. 7, app. 3 at 439; Snell, *supra* n.2, at 4, 7 tbl. 2; 18 U.S.C. § 3596(a). Nebraska abandoned electrocution in favor of lethal injection only in 2009 after the Nebraska Supreme Court found the electric chair unconstitutional under the state constitution. Denno, 102 GEO. L.J. at 1342.

Like Oklahoma, other States left their lethal injection statutes intentionally vague. *See* Denno, 63 OHIO ST. L.J. at 68-69; Denno, 76 FORDHAM L. REV. at 93. This delegation left the responsibility for developing execution protocols to corrections officials who had no specialized expertise. Prison officials thus had "unfettered discretion to determine all protocol and procedures, most notably the chemicals to be used, for a state execution." *Hobbs v. Jones*, 412 S.W.3d 844, 854 (Ark. 2012) (discussing Arkansas statute).

Ultimately, the federal government and almost every State that adopted lethal injection as an execution method also adopted the original three-drug protocol that Oklahoma had developed. *Baze*, 553 U.S.

at 43 (noting at least 30 States use the three-drug combination); *Evans v. State*, 914 A.2d 25, 76-77 & n.17 (Md. 2006) (similar). But, as this Court recognized, "it is undisputed that the States using lethal injection adopted the protocol first developed by Oklahoma without significant independent review of the procedure." *Baze*, 553 U.S. at 44 n.1; *see also Beardslee*, 395 F.3d at 1074 n.11 (noting California's protocol was "informally" based on the protocol in Texas and that "the precise protocol was never subjected to the rigors of scientific analysis.").

States copied the three-drug protocol despite the concerns that arose about it almost immediately. Soon after Oklahoma adopted the method, Chapman, Oklahoma's medical examiner, publicly discussed its potential dangers. *See* Jim Killackey, *Execution Drug Like Anesthesia*, DAILY OKLAHOMAN, May 12, 1977, at 1 ("Dr. A. Jay Chapman, state medical examiner, said that if the death-dealing drug is not administered properly, the convict may not die and could be subjected to severe muscle pain."). When Texas became the first State to employ the method in 1982, the Texas warden mistakenly mixed all three drugs into a single syringe, causing the mixture to turn into "white sludge." *See* STEPHEN TROMBLEY, THE EXECUTION PROTOCOL: INSIDE AMERICA'S CAPITAL PUNISHMENT INDUSTRY 74-75 (1992).

Indeed, the dangers attendant to the particular sequence of drugs were foreseeable even in 1977. *See, e.g.*, Simon Berlyn, *Execution By the Needle*, NEW SCIENTIST, Sept. 15, 1977, at 676-77 (describing the likely dangers of pairing a fast-acting barbiturate with a chemical paralytic, including the "terrifying possibility . . . that if an insufficient dose of barbiturates were given in execution," together with a paralytic, "a conscious victim would be unable to convey an

experience of intense suffering"). And before Oklahoma considered the method, Great Britain's Royal Commission on Capital Punishment had issued a 1953 report that concluded after a five-year study that lethal injection brought with it serious risks, ranging from the likely necessity of medical involvement to the potential difficulties of injecting an inmate with compromised veins. ROYAL COMMISSION ON CAPITAL PUNISHMENT 1949-1953 REPORT 257-61 (1953); Denno, 76 FORDHAM L. REV. at 64-65.

In the quarter-century that followed the first lethal injection execution, state prison officials continued to use the same lethal injection method, which resulted in numerous botched executions. Officials stabbed at inmates, trying to find suitable veins; intravenous lines infiltrated, sending the lethal chemicals into the tissue instead of the bloodstream; and inmates gasped and convulsed, apparently in pain. *See, e.g.*, Denno, 63 OHIO ST. L.J. at app. 1 at 139-41 tbl. 9; Denno, 76 FORDHAM L. REV. at 100-01.

B. State Prison Officials Continue To Follow The Same Historical Pattern In Relying Upon Insufficient Scientific And Medical Study In Modifying Lethal Injection Protocols.

Although nearly all States relied on the original three-drug sequence of sodium thiopental, pancuronium bromide, and potassium chloride at the time this Court agreed to hear *Baze*, that no longer is true today. Despite the Court's sanctioning of Kentucky's three-drug protocol, States have moved away from the three-drug combination in recent years. Such changes resulted from either court intervention or practical considerations as opposed to medical or scientific

study. Regardless of why any single State modified its protocol, other States often copied the new approach.

1. The Use Of A One-Drug Protocol

When this Court agreed to hear *Baze* in 2007, many States were grappling with challenges to lethal injection protocols. In California, for instance, a federal district court ruled in 2006 that the State could not carry out the execution of inmate Michael Morales using its standard three-drug protocol unless it provided qualified medical personnel in the field of general anesthesia to ensure that Morales was unconscious. *See Morales v. Hickman*, 415 F. Supp. 2d 1037, 1047-48 (N.D. Cal. 2006), *aff'd per curiam*, 438 F.3d 926 (9th Cir. 2006). As an alternative, the district court ruled that the execution could proceed if the State traded the historical three-drug protocol for a barbiturate-only protocol. *Id.* The State selected the alternative after the anesthesiologists scheduled to participate in the execution withdrew, but the State was unable to devise a one-drug protocol in time.[10] *Morales v. Tilton*, 465 F. Supp. 2d 972, 974-77 (N.D. Cal. 2006).

The following year, in September 2007, a federal district court in Tennessee deemed Tennessee's lethal

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[10] The same district court ruled in 2010 that California could use the one-drug protocol to execute inmate Albert Greenwood Brown, although that execution did not go forward. *Morales v. Cate*, Nos. 3:06-cv-00219, 3:06-cv-00926, 2010 WL 3751757, at *6-7 (N.D. Cal. Sept. 24, 2010) (providing for one-drug protocol); *Cal. Dep't of Corr. & Rehab. v. Superior Ct. of Marin Cnty.*, No. A129540, 2010 WL 3621873 (Cal. Ct. App. Sept. 20, 2010) (unpublished); Jack Leonard & Maura Dolan, *California Calls Off Brown Execution*, LOS ANGELES TIMES, http://latimesblogs.latimes.com/lanow/2010/09/california-calls-off-brown-execution.html (Sept. 29, 2010 4:25 p.m.).

injection protocol, adopted after a 90-day moratorium, unconstitutional. *Harbison v. Little*, 511 F. Supp. 2d 872 (M.D. Tenn. 2007), *rev'd*, 571 F.3d 531 (6th Cir. 2009). The panel constituted to evaluate Tennessee's lethal injection protocol had recommended that the State switch to a one-drug protocol that embodied fewer inherent risks. *Id.* at 877-78. But the Tennessee commissioner of corrections decided to retain the three-drug method. *Id.* at 886. In doing so, the commissioner declined to include any of the additional safeguards the panel had recommended. *Id.*

These decisions, however, pre-dated this Court's decision in *Baze*, which approved the three-drug method. Instead of fortifying the three-drug cocktail, however, States began to move toward a one-drug method that the petitioners in *Baze* had advanced and which the courts in California and Tennessee had approved.[11]

In switching to a one-drug protocol, States this time followed Ohio. In June 2008, less than two months after *Baze* was decided, a state court held that Ohio could no longer employ the standard three-drug protocol because the drug combination contravened Ohio's own lethal injection statute and therefore violated due process. *State v. Rivera*, No. 04CR065940, 2008 WL 2784679, slip op. at 1, 9 (Ohio Ct. Com. Pl. June 10, 2008). The Ohio court emphasized that "the use of two drugs in the lethal injection protocol (pancuronium bromide and potassium chloride) creates an unnecessary and arbitrary risk that the condemned

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[11] In addition, four states have abolished the death penalty since 2008. *See* Denno, 102 GEO. L. J. at 1343 n.73. New Mexico, Connecticut, and Maryland did not make the abolishment of the death penalty retroactive. *Id.*

will experience an agonizing and painful death." *Id.* at 6. The court proceeded to hold that the State's implementation of lethal injection should be through only "a lethal injection of a single, anesthetic drug." *Id.* at 9.

Ohio officially adopted a one-drug protocol using only sodium thiopental in 2009.[12] Prison officials in other States quickly followed suit, although many executions ended up using pentobarbital as a substitute for sodium thiopental. Denno, 102 GEO. L.J. at 1357-60. Washington State switched to the one-drug method in 2010, as did South Dakota in 2011. *Id.* at 1357-60. In 2012, another five states (Arizona, Georgia, Idaho, Missouri, and Texas) made the change and three states did so in 2013 (Arkansas, Kentucky, and Louisiana). *Id.* By 2013, prison officials in one-third of death penalty States had abandoned the three-drug sequence. *Id.* at 1360. Kentucky joined this group even though this Court had specifically rejected the argument in *Baze* that Kentucky should switch to a one-drug protocol, noting that using a single barbiturate was a method that "ha[d] not been adopted by any State and ha[d] never been tried." *Baze*, 553 U.S. at 40.

With so many States abandoning the three-drug protocol, "[i]n 2013, two-thirds of the lethal injection executions used a one-drug protocol compared to one-half of the lethal injection executions in 2012." Denno, 102 GEO. L.J. at 1360. States have continued to move

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[12] Ohio also permitted use of an alternative two-drug sequence that it implemented in 2014 in the execution of Dennis McGuire. Denno, 102 GEO. L.J. at 1357; Berger, 55 B.C.L. REV. at 1387.

to a one-drug protocol in increasing numbers.[13] *See State by State Lethal Injection*, DEATH PENALTY INFO. CENTER, http://www.deathpenaltyinfo.org/state-lethal-injection (last visited Mar. 15, 2015).

2. A Shift In The Drugs Used

At the same time certain States turned to the one-drug method, other States maintained rigid adherence to a three-drug protocol. All States began modifying the precise drugs used, however, due to pragmatic considerations.

Because of drug shortages, prison officials were forced to make substitutions for the first drug from the original three-drug sequence, sodium thiopental, in both one-drug and three-drug protocols. Denno, 102 GEO L.J. at 1362. "In 2009, the last domestic manufacturer of thiopental stopped making it." *Cook v. FDA*, 733 F.3d 1, 4 (D.C. Cir. 2013). Foreign manufacturers, aware of the use of the drug in lethal injections, declined to export the drug to the United States. Denno, 102 GEO L.J. at 1360-61, 1363-65. As a result, corrections officials sought out both alternative sources for sodium thiopental and substitutes for the drug.

Oklahoma made such a substitution in 2010. That year, when it could not obtain the sodium thiopental long used as the first drug in the sequence, Oklahoma became the first State to use pentobarbital, a drug

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[13] *See also Robinson v. Shanahan*, 755 S.E.2d 398, 398-99 (N.C. Ct. App. 2014); Maura Dolan, *California Will No Longer Pursue Three-Drug Lethal Injections*, LOS ANGELES TIMES http://articles.latimes.com/2013/jul/10/local/la-me-ln-lethal-injection-20130710 (Jul. 10, 2013).

used as a sedative or to control convulsions. Denno, 102 GEO. L.J. at 1362; *Pavatt v. Jones*, 627 F.3d 1336, 1340-41 (10th Cir. 2010) (rejecting challenge to substitution of pentobarbital as the first drug in the protocol). Other States also switched, at least temporarily, to the drug. Denno, 102 GEO. L.J. at 1358 cht. 3. By 2011, prison officials in thirteen States again had followed Oklahoma's lead and permitted the use of pentobarbital. *Id.*

But when the availability of pentobarbital became questionable, prison officials turned to compounding pharmacies to obtain it—a type of pharmacy unregulated by the Food and Drug Administration. *Id.* at 1364-71; *see also In re Lombardi*, 741 F.3d 888, 892, 895-97 (8th Cir. 2014) (en banc) (rejecting challenge to pentobarbital from compounding pharmacy), *reh'g denied*, 741 F.3d 903 (8th Cir. 2014), *cert. denied*, 134 S.Ct. 1790 (2014); *Whitaker v. Livingston*, 732 F.3d 465, 468 (5th Cir. 2013), *cert. denied sub nom., Yowell v. Livingston*, 134 S. Ct. 417 (2013) (same); *Wellons v. Comm'r Ga. Dep't of Corr.*, 754 F.3d 1260, 1265 (11th Cir. 2014) (same); Berger, 55 B.C.L. REV. at 1381. Compounded pentobarbital presented the additional risk of drug contamination, which can cause excruciating pain. Berger, 55 B.C.L. REV. at 1382-85; Denno, 102 GEO. L.J. at 1370-71, 1378-79 & n.329. The risks associated with the modified approach materialized in Oklahoma's problematic execution of Michael Lee Wilson in January 2014. Berger, 55 B.C.L. REV. at 1385 (describing witness accounts that Wilson cried out during his execution, "I feel my whole body burning!").

Correction officials in a handful of States now have turned to midazolam as a substitute for sodium thiopental. *See, e.g., Muhammad v. State*, 132 So.3d

176, 188 (Fla. 2013), *cert. denied*, 134 S. Ct. 894 (2014) (Florida); *Arthur v. Thomas*, No. 2:11-cv-438, 2015 WL 224738, at *1-2 & n.1 (M.D. Ala. Jan. 15, 2015) (Alabama). In 2014, four States conducted executions using midazolam, with two States using the drug in a three-drug protocol and the other two States using it as part of a two-drug protocol. *See Execution List 2014*, DEATH PENALTY INFO. CENTER, http://www.deathpenaltyinfo.org/execution-list-2014 (last visited Mar. 12, 2015); *see also In re Ohio Execution Protocol Litig.*, 994 F. Supp. 2d 906, 909 (S.D. Ohio 2014) (addressing Ohio's use of midazolam in two-drug protocol); Order, *Wood v. Ryan*, No. 2:14-cv-01447-NVW (D. Ariz. July 24, 2014), ECF No. 34 (discussing execution of Joseph Rudolph Wood).

Again, Oklahoma is one of these States. After the botched execution of Michael Lee Wilson in January 2014 using pentobarbital from a compounding pharmacy, Oklahoma substituted midazolam as the first drug in the three-drug sequence for the execution of Clayton Lockett in April 2014.[14] Berger, 55 B.C.L. REV. at 1386; *Warner v. Gross*, 776 F.3d 721, 725 (10th Cir. 2015). Lockett's execution was filled with egregious errors, including the inability to establish a reliable intravenous line. *See Warner*, 776 F.3d at 725. Although a doctor had declared Lockett unconscious, he apparently awoke at some point. *See id.*; OKLA. DEP'T OF PUB. SAFETY, THE EXECUTION OF CLAYTON D. LOCKETT: EXECUTIVE SUMMARY 18 (2014) (hereinafter "Lockett Execution Report"), *available at* http:// www.dps.state.ok.us/Investigation/14-0189SI%20Summary.pdf. Witnesses described Lockett as twitching,

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[14] Oklahoma's revised protocol provides four drug combinations, two of which called for large doses of a single barbiturate—either pentobarbital or sodium thiopental. *Warner v. Gross*, 776 F.3d 721, 726 (10th Cir. 2015).

gasping, convulsing violently, and calling out. Berger, 55 B.C.L. REV. at 1386. Prison officials discovered that the intravenous line had not worked as intended and some of the drugs had absorbed into Lockett's tissue or leaked out. *See id.*; Locket Execution Report at 11-12, 18-19; *Warner*, 776 F.3d at 725. State officials attempted to stop the execution, but Lockett died forty-three minutes after the first injection. *See* Lockett Execution Report at 18; Berger, 55 B.C.L. REV. at 1386; *Warner*, 776 F.3d at 725. Oklahoma investigated the botched execution, but still maintained the use of midazolam even though the drug does not have the same anesthetic properties as sodium thiopental. Berger, 55 B.C.L. REV. at 1386; Pet. Br. 19-22.

As a result of a flurry of changes to execution protocols, prison officials used four different drug combinations in lethal injection executions in 2014 alone.[15] The quick switches to new drugs stand in stark contrast to the consensus in support of the three-drug protocol at issue in *Baze*, which States had relied upon for more than thirty years.

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[15] *See Execution List 2014*, DEATH PENALTY INFO. CENTER, http://www.deathpenaltyinfo.org/execution-list-2014 (last visited Mar. 12, 2015). The four drug combinations were: (1) a three-drug protocol using midazolam; (2) a three-drug protocol using pentobarbital; (3) a two-drug protocol using midazolam and hydromorphone; and (4) a one-drug protocol using pentobarbital. *Id.*

III. JUDICIAL SCRUTINY OF PRISON OFFICIALS' ADMINISTRATION OF LETHAL INJECTION IS NECESSARY TO ENSURE COMPLIANCE WITH THE EIGHTH AMENDMENT.

As the history demonstrates, States adopted lethal injection generally and the three-drug protocol specifically without serious study or independent analysis. States uniformly followed Oklahoma in delegating to prison officials the details of lethal injections. Historical practice and contemporary evidence indicate that prison officials likely lack the necessary expertise to develop lethal injection protocols and fail to rely upon scientific or medical study. Yet these prison officials, operating outside the public eye, are tasked with developing procedures by which inmates will be executed. Because legislatures have delegated responsibility for such protocols to unelected officials, it is imperative that courts not insulate a State's protocol against challenge. Rather, the judiciary must provide a check on the exercise of such authority. In light of the recent trend toward constantly changing protocols, the courts have the constitutional responsibility to ensure such procedures comport with the Eighth Amendment.

A. Judicial Examination Of Modifications To Protocols Is Necessary Because The Actions Of Prison Officials Are Not Subject To Public Scrutiny And Oversight.

For a quarter century, States followed the three-drug protocol this Court approved in *Baze*. But prison officials did not arrive at the three-drug protocol after independent analysis and evaluation. Rather,

the protocol was "the product of administrative convenience and a stereotyped reaction to an issue, rather than a careful analysis of relevant considerations favoring or disfavoring a conclusion." *Baze*, 553 U.S. at 75 (Stevens, J., concurring in the judgment) (internal quotation marks omitted). In fact, "[i]n the majority of States that use the three-drug protocol, the drugs were selected by unelected department of correction officials with no specialized medical knowledge and without the benefit of expert assistance or guidance." *Id.* at 74-75.

Following *Baze*, States "have changed their lethal injection protocols in inconsistent ways that bear little resemblance to the original protocol evaluated in *Baze* and even differ from one execution to the next within the same state." Denno, 102 GEO. L.J. at 1331. Rather than correct for the unreasoned manner in which protocols had been adopted in the past, however, officials prioritize concern for administrative convenience over the need for a humane execution. Thus, as with the original three-drug protocol, such changes are not the result of careful deliberation. For this reason, "their drug selections are not entitled to the kind of deference afforded legislative decisions." *Baze*, 553 U.S. at 75 (Stevens, J., concurring in the judgment).

Prison officials in Oklahoma fall into this general pattern. Oklahoma first adopted pentobarbital for executions without any reasoned analysis. *Pavatt*, 627 F.3d at 1337; Pet. Br. at 11. Oklahoma then used pentobarbital from a compounding pharmacy, despite the well-documented risks associated with such pharmacies. Berger, 55 B.C.L. REV. at 1385. When pentobarbital became unavailable, Oklahoma prison officials turned to midazolam because Florida had

used the drug. Pet. Br. at 11. Oklahoma's reliance on another State's protocol without independent evaluation mirrored other States' adoption of Oklahoma's three-drug protocol nearly four decades ago.

Under these circumstances, judicial review provides a necessary means by which to examine the constitutionality of the chosen lethal injection drugs, procedures, and administration. *See, e.g.*, *Morales*, 465 F. Supp. 2d at 981 (holding California's protocol unconstitutional); *Harbison*, 511 F. Supp. 2d at 895, 903 (ruling State's failure to adopt one-drug protocol recommend by state-commissioned study violated the Eighth Amendment); *Taylor v. Crawford*, No. 2:07-cv-04129, 2006 WL 1779035, at *8 (W.D. Mo. June 26, 2006), *rev'd*, 487 F.3d 1072 (8th Cir. 2007) (concluding that Missouri's lethal injection procedure presented unconstitutional risk due to maladministration).

Following *Baze*, however, challenges to lethal injection protocols were cut short in misplaced reliance on the decision. Indeed, a majority of the cases cite the "*Baze* substantial-risk standard to establish that the method of injection and the drugs administered did not pose a risk sufficient to constitute an Eighth Amendment violation." Denno, 102 GEO L.J. at 1349. Reliance on this aspect of *Baze* persisted in spite of numerous changes to lethal injection protocols. *Id.*

But the plurality opinion in *Baze* did not seek to insulate lethal injection protocols from scrutiny. *Baze*, 553 U.S. at 62. The opinion specifically contemplated changes to the method "in light of new developments, to ensure humane capital punishment." *Id.*

Although the Court anticipated legislative changes, *Baze*, 553 U.S. at 62, the types of challenges at issue

in *Baze* (concerning the risk of improper administration) and here (concerning drug selection) do not involve matters on which legislatures historically have spoken. While the courts need not serve as "boards of inquiry charged with determining 'best practices' for executions," *id.* at 51 (plurality op.), each new combination of drugs must be evaluated independently.

Such judicial oversight would not "substantially intrude on the role of state legislatures in implementing their execution procedures," *id.*, because legislatures do not concern themselves with the intricacies of lethal injection procedures.[16] Thus, as Justice Stevens explained, "[t]he question whether a similar three-drug protocol may be used in other States remains open, and may well be answered differently in a future case on the basis of a more complete record." *Id.* at 71 (Stevens, J., concurring in the judgment).

The development of such records is critical. History demonstrates that the lethal injection protocols that

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[16] Recently, legislatures that have proposed bills addressing execution methods have sought to bring back methods of execution abandoned in favor of lethal injection. Oklahoma is considering a bill that would revive a modified form of lethal gas using nitrogen instead of cyanide. *See, e.g.*, Sean Murphy, *Nitrogen Gas Executions Approved By Oklahoma*, ABC NEWS, http://abcnews.go.com/US/wireStory/nitrogen-gas-executions-approved-oklahoma-house-29354885 (Mar. 3, 2015 4:14 p.m.). The Utah Senate approved a statutory amendment that would allow the State to use the firing squad if the State cannot obtain lethal injection drugs. Kelly Catalfamo & Michelle L. Price, *Utah Lawmakers Vote to Allow Firing Squad*, ABC NEWS, http://abcnews.go.com/US/wireStory/lawmakers-vote-state-firing-squad-29542718 (Mar. 11, 2015 12:48 a.m.). And Tennessee amended its statute to allow for the use of electrocution if the drugs for lethal injection are not available. Tenn. Code Ann. § 40-23-114(e)(2).

prison officials created embodied constitutionally unacceptable risks. Even when faced with evidence of botched executions involving the exact same combination of drugs, States have proceeded to use the protocol. Closer examination of such procedures was (and remains) hindered and, in some cases, foreclosed by the secretive nature in which prison officials develop and ultimately carry out their lethal injection protocols. Denno, 76 FORDHAM L. REV. at 121-23; Berger, 55 B.C.L. REV. at 1388-95. Thoughtful examination will continue only if this Court reinforces the necessity of Eighth Amendment review of prison officials' chosen lethal injection drugs and procedures.

B. The Delegation Of Lethal Injection Procedures To Prison Officials Permits Corrective Revision Of Protocols To Ensure Compliance With The Eighth Amendment.

Although the delegation to prison officials of the details of lethal injection means that protocols require careful judicial scrutiny, such delegation also provides States with the flexibility to adjust protocols if a court deems an aspect unconstitutional. Thus, no reason exists to require an inmate to identify a specific alternative to a challenged protocol. To the contrary, legislatures and courts should not be permitted to transfer the responsibility for an execution that comports with the Eighth Amendment to the condemned inmate.

When Oklahoma first declined to include the details of the protocol in its lethal injection statute in 1977, it did so with the idea that different drug combinations might become available. Denno, 76 FORDHAM L. REV. at 67.

In recent years, this remnant of the adoption of lethal injection has permitted inmates to challenge the specific lethal injection procedures promulgated by

prison officials pursuant to 42 U.S.C. § 1983, which governs challenges to circumstances of confinement. In such actions, a ruling deeming a protocol unconstitutional would not render lethal injection itself unconstitutional because States' lethal injection statutes do not embody the specifics of lethal injection procedures.

In *Nelson v. Campbell*, 541 U.S. 637 (2004), this Court permitted to proceed as a Section 1983 claim a challenge by a condemned inmate to the planned use of a cut-down procedure—a painful and invasive way to establish intravenous access. *Id.* at 642-46. The Court explained the suit was allowed because the petitioner did not seek to challenge lethal injection itself, but rather challenged only the cut-down procedure. *Id.*

Two year later, in *Hill v. McDonough*, 547 U.S. 573 (2006), the petitioner inmate challenged the constitutionality of Florida's three-drug protocol. The Court held that challenges to state protocols were permissible Section 1983 actions because success "would not necessarily prevent the State from executing [the inmate] by lethal injection." *Id.* at 580.

And *Baze* concerned whether the non-drug aspects of Kentucky's protocol presented an unnecessary risk of pain and suffering if the three-drug protocol were not administered properly. *Baze*, 553 U.S. at 40 (explaining that petitioners contended only that Kentucky's protocol violated the Eight Amendment "because of the risk that the protocol's terms might not be properly followed, resulting in significant pain").

In this regard, because legislatures delegate to prison officials the details of lethal injection executions, a State retains the flexibility to implement an

alternative to its chosen procedure if needed.[17] State corrections officials have demonstrated over time the ability to respond to a variety of practical concerns and have the same ability to respond to constitutional concerns if required to do so. *See Hill*, 547 U.S. at 580-81 (explaining that Florida "leaves implementation [of lethal injection] to the department of corrections," and "does not require the department of corrections to use the challenged procedure," thereby "leav[ing] the State free to use an alternative lethal injection procedure") (citing Fla. Stat. §§ 922.105(1), (7)); *see also Jones v. Bock*, 549 U.S. 199, 213 (2007) (describing *Hill* as "unanimously reject[ing] a proposal that § 1983 suits challenging a method of execution must identify an acceptable alternative").

In this way, the intentional vagueness of lethal injection statutes allows prison officials to take corrective action if a certain protocol is found unconstitutional. Accordingly, challenges to lethal injection protocols should not be restricted to instances in which an inmate can identify a specific available alternative.

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[17] A protocol may be subject to some scrutiny through state administrative enactment procedures, but certain States exempt lethal injection protocols from review. *Compare Sims v. Dep't of Corr. & Rehab.*, 157 Cal. Rptr. 3d 409, 428 (Cal. Ct. App. 2013) (invalidating protocol for failure to comply with state administrative procedure act) *and Bowling v. Kentucky Dep't of Corr.*, 301 S.W.3d 478, 492 (Ky. 2010) (similar) *with Hill v. Owens*, 738 S.E.2d 56, 64 (Ga. 2013) (holding state administrative procedure act did not apply to lethal injection protocol, "specifically the choice of the drug or drugs that are appropriate at any given time") *and Abdur'Rahman v. Bredesen*, 181 S.W.3d 292, 311-12 (Tenn. 2005) (noting lethal injection protocol exemption from state administrative procedure act).

CONCLUSION

The judgment of the Tenth Circuit should be reversed.

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF OF *AMICUS CURIAE* NATIONAL ASSOCIATION OF CRIMINAL DEFENSE LAWYERS IN SUPPORT OF PETITIONERS

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Library of Congress
Law Library

TABLE OF CONTENTS

Page

TABLE OF CONTENTS..... i

TABLE OF CITED AUTHORITIES ii

STATEMENT OF INTEREST OF *AMICUS CURIAE*.....1

SUMMARY OF ARGUMENT 2

ARGUMENT..... 3

I. NACDL Opposes the Death Penalty in All Cases, Regardless of the Method of Execution 3

II. The Role of the Capital Defense Lawyer Whose Client Is Facing Execution 5

III. The Conduct of the State of Oklahoma Is Inconsistent With the Values of our Society and our Constitution 7

CONCLUSION 10

TABLE OF CITED AUTHORITIES

Page

Cases

Baze v. Rees,
553 U.S. 35 (2008) 3, 6, 9

Callins v. Collins,
510 U.S. 1141 (1994) 3, 6

DeShaney v. Winnebago County Dep't of Soc. Services,
489 U.S. 189 (1989) 7

Furman v. Georgia,
408 U.S. 238 (1972) 3

Gregg v. Georgia,
428 U.S. 227 (1976) 3, 4, 7

In re Kemmler,
136 U.S. 436 (1890) 7

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99 U.S. 130 (1878) 7

Statutes and Other Authorities

Anthony T. Kronman, Tribute to Burke Marshall,
113 Yale L.J. 807 (Jan. 2004) 7

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Cited Authorities

Page

Death Penalty Information Center, Facts About the Death Penalty (Feb. 11, 2015), available at http://www.deathpenaltyinfo.org 4, 5

Ethan Bronner, Use of Death Sentences Continues to Fall in U.S., N.Y. Times, Dec. 20, 2012 4

Gallup, Death Penalty, http://www.gallup.com/poll/1606/Death-Penalty.aspx. 4

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Ian Lovett, Executions Are Suspended by Governor in Washington, N.Y. Times, Feb. 13, 2014.....4

Pennsylvania: Governor Halts Executions, N.Y. Times, Feb. 13, 2015 4

Timothy Williams, States Execute Fewest Convicts in 20 Years, Report Finds, N.Y. Times, Dec. 18, 2014 4

STATEMENT OF INTEREST OF AMICUS CURIAE[1]

The National Association of Criminal Defense Lawyers (NACDL) is a nonprofit voluntary professional bar association that works on behalf of criminal defense attorneys to ensure justice and due process for those accused of crime or misconduct.

NACDL was founded in 1958. It has a nationwide membership of approximately 10,000 and up to 40,000 with affiliates. NACDL's members include private criminal defense lawyers, public defenders, military defense counsel, law professors, and judges. NACDL is the only nationwide professional bar association for public defenders and private criminal defense lawyers. The American Bar Association recognizes NACDL as an affiliated organization and awards it representation in its House of Delegates.

NACDL is dedicated to advancing the proper, efficient, and just administration of justice. NACDL files numerous briefs as *amicus curiae* each year, in the United States Supreme Court and other courts, seeking to provide assistance in cases that present issues of broad importance to criminal defendants, criminal defense lawyers, and

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1. Each party has consented to the filing of this *amicus curiae* brief in support of petitioners. No counsel to a party in this case authored this brief in whole or in part. No party or party's counsel made any monetary contribution that was intended to or did fund the preparation or submission of this brief. No person or entity, other than the *amicus* and its counsel, made any monetary contribution that was intended to or did fund the preparation or submission of this brief.

the criminal justice system as a whole. NACDL has a particular interest in this case due to its opposition to the death penalty and its members' representation of capital defendants who may face execution by lethal injection.

SUMMARY OF ARGUMENT

Amicus curiae National Association of Criminal Defense Lawyers (NACDL) is opposed to the death penalty in all cases, regardless of the method of execution. NACDL recognizes, however, that it is inevitable that individuals convicted of capital crimes will continue to be executed by lethal injection, at least for the time being.

Given that reality, NACDL believes the drug protocol adopted by the State of Oklahoma violates the Eighth Amendment's prohibition against cruel and unusual punishment. The protocol at issue, which relies on the use of midazolam for the prevention of pain, was devised in unseemly haste, based on incomplete information derived largely from an Internet search, by officials lacking any expertise regarding the drugs involved and facing political pressure to find some way to carry out executions that were already scheduled. Petitioners are entitled under our Constitution to expect that their executions will be carried out in as humane a manner as possible, but the actions of the State of Oklahoma have made that impossible. NACDL urges this Court to reverse the decision below and hold that the State of Oklahoma's execution drug protocol is unconstitutional.

ARGUMENT

I. NACDL Opposes the Death Penalty in All Cases, Regardless of the Method of Execution

Amicus curiae NACDL is unalterably opposed to the death penalty in all circumstances, no matter how the sentence of death is carried out. NACDL respectfully submits that the death penalty is unjust, uncivilized, and inconsistent with the inherent fallibility of the American criminal justice system, and therefore unconstitutional. *See, e.g., Baze v. Rees*, 553 U.S. 35, 86 (2008) (Stevens, J., concurring in the judgment) ("the imposition of the death penalty represents 'the pointless and needless extinction of life with only marginal contributions to any discernible social or public purposes. A penalty with such negligible returns to the State [is] patently excessive and cruel and unusual punishment violative of the Eighth Amendment.'") (quoting *Furman v. Georgia*, 408 U.S. 238, 312 (1972) (White, J., concurring)); *Gregg v. Georgia*, 428 U.S. 227, 241 (1976) (Marshall, J., dissenting) ("The death penalty, unnecessary to promote the goal of deterrence or to further any legitimate notion of retribution, is an excessive penalty forbidden by the Eighth and Fourteenth Amendments."); *Callins v. Collins*, 510 U.S. 1141, 1145 (1994) (Blackmun, J., dissenting from denial of certiorari) ("It is virtually self-evident to me now that no combination of procedural rules or substantive regulations ever can save the death penalty from its inherent constitutional deficiencies.").

NACDL remains hopeful that as the American people learn more about the realities of racial disparity, arbitrary

application, and mistaken convictions,[2] the movement away from capital punishment will gain momentum. The percentage of Americans who support the death penalty has declined in recent years,[3] while a number of states – one per year during the period 2008-2012 – have banned it altogether.[4]

At the same time, NACDL recognizes that capital punishment is, at least for the time being, an inescapable reality of our criminal justice system. Over 1,400 individuals have been executed since the death penalty was reinstated in 1976.[5] *See Gregg v. Georgia*, 428 U.S. 153 (1976). The number of executions has fallen in recent years, but despite the decline, 35 people were put to death in 2014 and 72 were newly sentenced to death.[6] A majority of Americans continue to favor the death penalty, and a

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2. Since 1973, over 140 people have been released from death row based on evidence of their innocence. Death Penalty Information Center, Facts About the Death Penalty (Feb. 11, 2015), available at http://www.deathpenaltyinfo.org (hereinafter "DPIC Fact Sheet").

3. Gallup, Death Penalty, http://www.gallup.com/poll/1606/Death-Penalty.aspx.

4. Ethan Bronner, Use of Death Sentences Continues to Fall in U.S., N.Y. Times, Dec. 20, 2012, at A24. Most recently, Pennsylvania imposed a moratorium on executions, as have a number of other states in recent years. Pennsylvania: Governor Halts Executions, N.Y. Times, Feb. 13, 2015, at A14; Ian Lovett, Executions Are Suspended by Governor in Washington, N.Y. Times, Feb. 13, 2014, at A12.

5. DPIC Fact Sheet, *supra* note 2.

6. Timothy Williams, States Execute Fewest Convicts in 20 Years, Report Finds, N.Y. Times, Dec. 18, 2014, at A22.

majority of states continue to carry death penalty statutes on their books. While NACDL continues to hope and advocate for a moratorium on executions and abolition of capital punishment, and believes this country is moving toward those objectives, we cannot realistically expect that there will be no more executions in the United States.

As of October 1, 2014, over 3,000 individuals were being held under sentence of death by 35 different states and the federal government.[7] Many of those individuals are, of course, still in various stages of appeal and post-conviction proceedings. Many are represented by dedicated and zealous lawyers – whether public defenders, private defense attorneys, pro bono attorneys, or capital punishment resource centers – who will continue to advocate for their clients as long as any forum for that advocacy remains available to them. At least some will eventually see their death sentences overturned or commuted. But inevitably, some of those 3,000 men and women will reach the end of their road. All avenues for appeal, petitions for writ of habeas corpus, and requests for clemency will be exhausted, execution dates will be set, and stays of execution denied.

II. The Role of the Capital Defense Lawyer Whose Client Is Facing Execution

Atticus Finch famously taught us that "You never really understand a person until you consider things from his point of view . . . until you climb into his skin and walk

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7. Death Penalty Information Center, Death Row Inmates by State, http://www.deathpenaltyinfo.org/death-row-inmates-state-and-size-death-row-year.

around in it."[8] Through the sometimes long and always difficult journeys to Death Row that they have shared with their clients, these lawyers have told the stories of the men and women charged with capital offenses – often stories of mental illness, violence, and abuse. They have truly walked in the skins of those convicted of often-heinous crimes, and have done their utmost to communicate and share that experience with juries and judges. Once their efforts have failed and their clients are facing execution, what is left for them to do?

Cases like that of Richard Glossip and his fellow petitioners call upon us, their lawyers, at a minimum to assure those who are facing imminent imposition of the sentence of death that their constitutional rights will be protected. Each of them will shortly become, in the words of Justice Blackmun, "no longer a defendant, an appellant, or a petitioner, but a man, strapped to a gurney, and seconds away from extinction." *Callins v. Collins*, 510 U.S. 1141, 1143 (1994) (Blackmun, J., dissenting from denial of certiorari). In those moments, we should be able to tell them that while they may suffer,[9] they will suffer as little as possible; that the state that has chosen to deprive them of life as punishment for their crimes has assured itself that the process will be humane; that they will, at a minimum, be treated with dignity and respect for their humanity in their final moments; that their execution will be carried out in a manner that meets the legal standards of our Constitution and the moral standards of a just and

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8. Harper Lee, To Kill a Mockingbird 39 (Grand Central Publishing 1982) (1960).

9. "It is clear . . . that the Constitution does not demand the avoidance of all risk of pain in carrying out executions." *Baze v. Rees*, 553 U.S. 35, 47 (2008).

compassionate society.[10] *See, e.g., Gregg*, 428 U.S. at 173 (Stewart, Powell, and Stevens, JJ.) ("A penalty . . . must accord with 'the dignity of man,' which is the 'basic concept underlying the Eighth Amendment.'") (citation omitted); *In re Kemmler*, 136 U.S. 436, 447 (1890) ("[p]unishments are cruel when they involve torture or a lingering death"); *Wilkerson v. Utah*, 99 U.S. 130, 136 (1878) (torture and unnecessary cruelty are forbidden by the Constitution).

But as discussed below, the State of Oklahoma has made it impossible for us to provide any of those assurances to these petitioners or to their fellow inmates on Oklahoma's Death Row.

III. The Conduct of the State of Oklahoma Is Inconsistent With the Values of our Society and our Constitution

The record in this case demonstrates the following:

- The initial drug protocol that Oklahoma adopted in March 2014 was decided upon by lawyers and correctional officials. They devised this particular combination of drugs without consulting with

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10. Just as compassion "need not be exiled from the province of judging," *DeShaney v. Winnebago County Dep't of Soc. Services*, 489 U.S. 189, 213 (1989) (Blackmun, J., dissenting), so it need not be exiled from the practice of law. *See also* Clarence Darrow, The Story of My Life 450 (Charles Scribner's Sons 1932) ("I have followed my instincts and feelings and sought to rescue the suffering when I could."); Anthony T. Kronman, Tribute to Burke Marshall, 113 Yale L.J. 807, 809 (Jan. 2004) (we must invoke "the promise of the law" on behalf of "those whose humanity fails to register in the eyes of others").

pharmacologists, medical professionals, or anyone else with expertise concerning the drugs involved.

- Under pressure from the offices of the Governor and the state Attorney General to avoid any delay in carrying out the scheduled execution of Clayton Lockett, the former General Counsel of the state's corrections department came up with the choice of midazolam largely by surfing the Internet – "Wiki leaks, or whatever it is," as he put it.

- In continuing to pursue the use of midazolam, the State of Oklahoma is choosing to disregard the fact that at this point, at least three men – Dennis McGuire in Ohio, Joseph Wood in Arizona, and Mr. Lockett in Oklahoma – have suffered protracted and possibly torturous deaths when midazolam was used as part of their execution protocol. And given the use of paralytics, it is certainly possible that Charles Warner in Oklahoma, as well as the men who were executed in Florida using a protocol that included midazolam, have endured the same experience, but with the additional horror of not being able to communicate their suffering.

In short, the record establishes that the State of Oklahoma engaged in an unseemly scramble, in the interest of political expediency, to find some method of execution it could apply quickly, regardless of what turned out to be the horrific consequences to Mr. Lockett. Moreover, and even more inexplicably, the State of Oklahoma continues to pursue its right to administer this same drug protocol to the petitioners now before this Court – despite the risk that they will suffer the same

agonizing death as others who have been subjected to execution by a protocol that relies on midazolam for the prevention of pain. At this point, and given the extensive evidence regarding midazolam that has been submitted by petitioners in this proceeding, there is no reason for the State of Oklahoma to refuse to adopt a drug protocol that, like the protocol in *Baze*, all sides can agree is humane if administered correctly.

This record hardly presents a picture of a humane criminal justice system. Nor does it allow defense attorneys to vindicate the constitutional rights of those facing execution by reassuring them that they will not have to endure excessive pain. While NACDL hopes that none of the capital defendants its members represent will ever reach the lethal injection chamber, we must expect that some of them will. Accordingly, NACDL urges this Court, consistent with the humanity and compassion that we believe to be inherent in the strictures of the Eighth Amendment and the values we share as a society, to reverse the holding of the Tenth Circuit Court of Appeals and hold that Oklahoma's execution drug protocol is unconstitutional.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Tenth Circuit should be reversed.

Respectfully submitted,

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF CITED AUTHORITIES iii

INTEREST OF *AMICUS CURIAE* 1

SUMMARY OF ARGUMENT 3

ARGUMENT 5

I. *AMICUS CURIAE*'S VIEWS ARE RELEVANT IN INTERPRETING THE EIGHTH AMENDMENT 5

II. METHODS OF EXECUTION THAT ARE EXPERIMENTAL AND CAUSE UNDUE SUFFERING ARE AN AFFRONT TO HUMAN DIGNITY AND SHOULD NOT BE PERMITTED 8

A. Oklahoma's Use of Midazolam in Conjunction with a Paralytic and Potassium Chloride Creates a Substantial Risk of Torture 8

B. The Experimental Use of Midazolam in Lethal Injection Procedures Violates the Physical and Psychological Integrity of Human Beings 11

Table of Contents

Page

C. The Brutality of Recent Problematic Executions Devalues Human Life and Erodes Our Sense of Innate Human Dignity 13

CONCLUSION 16

TABLE OF CITED AUTHORITIES

Page

CASES

Abdullahi v. Pfizer, Inc.,
562 F.3d 163 (2d Cir. 2009) 12

Atkins v. Virginia,
536 U.S. 304 (2002) 4, 7

Baze v. Rees,
553 U.S. 35 (2008) 9, 10, 11

Bowen v. Kendrick,
487 U.S. 589 (1988) 7

Coker v. Georgia,
433 U.S. 584 (1977) 5, 6

Enmund v. Florida,
458 U.S. 782 (1982) 6

Graham v. Florida,
560 U.S. 48 (2010) 5, 6, 9

Gregg v. Georgia,
428 U.S. 153 (1976) 4, 5

Hall v. Florida,
134 S. Ct. 1986 (2014) 14

Hope v. Pelzer,
536 U.S. 730 (2002) 9

Cited Authorities

Page

In re Kemmler,
136 U.S. 436 (1890) 9, 10

Lockhart v. McCree,
476 U.S. 162 (1986) 5

Malinski v. New York,
324 U.S. 401 (1945) 12

McCleskey v. Kemp,
481 U.S. 279 (1987) 5

Penry v. Lynaugh,
492 U.S. 302 (1989) 6

Ring v. Arizona,
536 U.S. 584 (2002) 4

Rochin v. California,
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INTEREST OF *AMICUS CURIAE*[1]

The National Catholic Reporter (the "NCR") was established in 1964 as an independent journalistic outlet for Catholics and others who struggle with the complex moral and societal issues of the day. The NCR's mission is to connect Catholics to church, faith, and the common good with independent news, analysis and spiritual reflection. It focuses on marrying the religious, political and social forces shaping public policies and institutions. It is a significant alternative Catholic voice that provides avenues for expression of diverse perspectives.

The NCR was the first newspaper of its kind, embracing the revolutionary idea that Catholics need access to news of the Church in order to be active participants and strong voices on important issues. Having developed through the inspiration of the Second Vatican Council, the NCR's spirit is independent, its management lay, and its vision ecumenical. The NCR publishes a biweekly print newspaper and has expanded its online reach to more than 4 million readers.

The NCR and its readership have a strong interest in the defense and promotion of human life and dignity. *See* Catechism of the Catholic Church ¶ 1930 (available at http://www.vatican.va/archive/ENG0015/_INDEX.HTM) (hereinafter Catechism). This interest is reflected in the

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1. Pursuant to Rule 37.6, *amicus curiae* certifies that this brief was not written in whole or in part by counsel for any party, and no person or entity other than *amicus curiae* and its counsel has made a monetary contribution to the preparation and submission of this brief. Letters from the parties consenting to the filing of this brief have been filed with the Clerk of the Court.

Catholic Church's decades-old opposition to the death penalty. More than thirty years ago, Catholic Bishops in the United States called for an end to the death penalty in the United States. They did so based on a conviction that "in the conditions of contemporary American society, the legitimate purposes of punishment do not justify the imposition of the death penalty." U.S. Bishops' Statement on Capital Punishment ¶ 9 (Nov. 1980) (available at http://www.usccb.org/issues-and-action/human-life-and-dignity/death-penalty-capital-punishment/statement-on-capital-punishment.cfm); *see also* Statement of the Administrative Board, United States Catholic Conference, *A Good Friday Appeal to End the Death Penalty* (March 1999) (available at http://www.usccb.org/issues-and-action/human-life-and-dignity/death-penalty-capital-punishment/good-friday-appeal.cfm).

Under the Church's teachings, the execution of another human being is justified only "in cases of absolute necessity"—that is, when "it would not be possible otherwise to defend society." Pope John Paul II, Evangelium Vitae (The Gospel of Life) ¶ 56 (available at http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html). "Today . . . as a result of steady improvements in the organization of the penal system, such cases are very rare if not practically non-existent." *Id.* "In January 1999, John Paul II applied this 'absolute necessity' rubric specifically to the United States and found that imposition of the death penalty in this country was 'both cruel and unnecessary.'" *See* Art C. Cody, *The King's Good Servants: Catholics as Participants in Capital Litigation*, 44 J. Catholic Legal Stud. 283, 285 (2005). Pope Francis recently noted, "[i]t is impossible to imagine that states today cannot make

use of another means than capital punishment to defend peoples' lives from an unjust aggressor." David Gibson & Josephine Mckenna, *Pope Francis blasts supermax prisons as 'torture'*, Washington Post, Oct. 23, 2014.

The issues in this case present serious concerns that underlie the Church's opposition to the death penalty. As demonstrated in Petitioner's Brief, the use of midazolam—a new and untested drug with respect to administration of the death penalty—in combination with a paralytic drug and potassium chloride, causes substantial physical and mental pain and suffering to the persons executed. Based on religious convictions, *amicus curiae* and its readership have an interest in ensuring that human beings are not subjected to the suffering that this method of execution entails. Indeed, in a jointly published editorial, the NCR and three other major Catholic publications—*America*, *National Catholic Register*, and *Our Sunday Visitor*—focused on the brutal nature of these executions to underscore the already existing need to abolish the death penalty in United States. *See* Editorial, *Catholic Publications Call for End to Capital Punishment*, March 5, 2015, http://ncronline.org/news/peace-justice/editorial-catholic-publications-call-end-capital-punishment.

SUMMARY OF ARGUMENT

Catholics believe that human beings are created in the image of God. A just and moral society treats human life with the utmost respect. Those Catholic teachings are consistent with this Court's precedent recognizing the sanctity of human life. *See, e.g.*, *Roper v. Simmons*, 543 U.S. 551, 571 (2005) (noting that the death penalty is "the

most extreme sanction available to the State") (quoting *Atkins v. Virginia*, 536 U.S. 304, 319 (2002)); *see also Ring v. Arizona*, 536 U.S. 584, 605-06 (2002) ("[T]here is no doubt that death is different.") (internal quotation marks omitted). In cases concerning the extinguishment of human life prior to natural death, the Court "has been particularly sensitive to insure that every safeguard is observed." *Gregg v. Georgia*, 428 U.S. 153, 187 (1976).

The use of midazolam as an anesthetic ahead of other drugs meant to paralyze and prematurely extinguish human life is inconsistent with Catholic teachings and this Court's precedent. The deliberate use of midazolam in executions despite scientific evidence that it is incapable of maintaining a deep coma-like unconsciousness, which is necessary to prevent the condemned from feeling substantial physical and mental pain prior to death, amounts to torture. Torture is prohibited by the Church and this Court. The Food and Drug Administration has not approved midazolam as a sole anesthetic, and its use in executions also amounts to impermissible experimentation. At core, the brutality associated with executions using midazolam fundamentally undermines the innate dignity of human life revered by so many Americans with religious convictions and embodied in our country's legal traditions.

Amicus curiae urges the Court to find that the use of midazolam during the execution process violates the Eighth Amendment's ban on cruel and unusual punishment.

ARGUMENT

I. *AMICUS CURIAE*'S VIEWS ARE RELEVANT IN INTERPRETING THE EIGHTH AMENDMENT

To determine whether a punishment is cruel and unusual under the Eighth Amendment, "courts must look beyond historical conceptions to the evolving standards of decency that mark the progress of a maturing society." *Graham v. Florida*, 560 U.S. 48, 58 (2010) (internal citations and quotation marks omitted). The meaning of "cruel and unusual" is "not fastened to the obsolete"; rather, it "acquire[s] meaning as public opinion becomes enlightened by a humane justice." *Weems v. United States*, 217 U.S. 349, 378 (1910). In other words, a determination of what the Eighth Amendment bans as "cruel and unusual" depends on the moral sensibilities of modern society.

In applying the Eighth Amendment, this Court identifies society's moral sensibilities by looking to various indicators that "reflect the public attitude toward a given sanction." *Stanford v. Kentucky*, 492 U.S. 361, 370 (1989) (citation omitted). These include actions of legislatures and jury sentencing records. *McCleskey v. Kemp*, 481 U.S. 279, 300 (1987); *Coker v. Georgia*, 433 U.S. 584, 596 (1977) (plurality opinion). But on matters involving a moral judgment—and, in particular, the death penalty—guidance from legislative bodies and juries is insufficient. *See Gregg*, 428 U.S. at 174 n.19 (plurality opinion) ("[L]egislative judgments alone cannot be determinative of Eighth Amendment standards since that Amendment was intended to safeguard individuals from the abuse of legislative power"); *Lockhart v. McCree*, 476 U.S. 162, 173-74, 176 (1986) (acknowledging that determinations by

juries do not reflect a national consensus on moral issues such as the death penalty because persons opposed to the death penalty are required to be excluded from sentencing deliberations).

As a result, this Court often looks beyond legislatures and juries to determine what society sees as "cruel and unusual." For example, in interpreting the Eighth Amendment this Court has considered the views of professional organizations, the common law, the actions of prosecutors, commutation records, and the laws of other nations. *See Thompson v. Oklahoma*, 487 U.S. 815, 830 (1988) (plurality opinion) (citing views of professional organizations); *Coker*, 433 U.S. at 592-93 (plurality opinion) (citing common law); *id.* at 592 n.4, 593, 596 n.10 (citing history and laws of other nations); *Enmund v. Florida*, 458 U.S. 782, 788-89, 796 n.22 (1982) (citing historical developments, commutation records and laws of other nations); *id.* at 796 (citing prosecutorial decisions to pursue the death penalty); *Trop v. Dulles*, 356 U.S. 86, 102 & n.35 (1958) (plurality opinion) (citing laws of other nations).

This Court has recognized that the death penalty and its implementation involve quintessentially moral questions. *See, e.g., Penry v. Lynaugh*, 492 U.S. 302, 319 (1989) ("Thus, the sentence imposed at the penalty stage should reflect a reasoned moral response to the defendant's background, character, and crime.") (citation omitted). Indeed, determining a "standard of extreme cruelty . . . necessarily embodies a moral judgment." *Graham*, 560 U.S. at 58. The Eighth Amendment draws its meaning from "'the evolving standards of decency that mark the progress of a maturing society.'" *Id.* (quoting *Trop*, 356 U.S. at 101 (plurality opinion)).

Institutions such as *amicus curiae* serve as moral guides for millions of Americans. The views of these institutions thus provide an important benchmark of the Nation's "evolving standards of decency." For this reason, this Court has considered the views of religious institutions in determining what punishments are abhorrent and thus "cruel and unusual" under the Eighth Amendment. *See Atkins v. Virginia*, 536 U.S. 304, 316 n.21 (2002) (citing *amicus* brief of United States Catholic Conference and other religious organizations as "additional evidence" of a broad "social and professional consensus" against the execution of persons with mental retardation); *see also Stanford*, 492 U.S. at 388 n.4 (Brennan, J., dissenting, joined by Marshall, J., Blackmun, J., and Stevens, J.) (citing views of religious groups in considering the constitutionality of imposing the death penalty on a juvenile); *cf. Bowen v. Kendrick*, 487 U.S. 589, 606-07 (1988) (discussing the role of religious organizations in addressing secular problems in society).

From the Nation's founding, and especially during times of intense debate on moral issues, religious institutions have played a pivotal role in shaping the national conscience. The views of religious institutions, including *amicus curiae*, should be considered when evaluating the implementation of the most extreme penalty that can be imposed on a human being: the taking of a human life prior to natural death.

II. METHODS OF EXECUTION THAT ARE EXPERIMENTAL AND CAUSE UNDUE SUFFERING ARE AN AFFRONT TO HUMAN DIGNITY AND SHOULD NOT BE PERMITTED

A. Oklahoma's Use of Midazolam in Conjunction with a Paralytic and Potassium Chloride Creates a Substantial Risk of Torture

As discussed in Petitioner's Brief, the scientific community is in agreement that midazolam is pharmacologically incapable of maintaining the deep coma-like unconsciousness necessary to prevent the condemned from feeling substantial physical pain and suffering prior to death. *See generally* Pet. Br. at 13-17. The use of midazolam in executions creates a substantial risk that the condemned will suffer torturous pain or suffering prior to death. The Church's teachings prohibit torture in any form or method.

The Catechism of the Church identifies torture as a grave sin that violates the Fifth Commandment. *See* Catechism ¶¶ 2258-2330. Pope Francis has referred to torture as a "mortal sin" and has reiterated his "firm condemnation of all forms of torture." Charles Poladian, *Pope Francis Angelus Prayer: Torture A 'Very Grave Sin,' Calls For Its End In Sunday's Address*, Int'l Business Times, June 22, 2014. Pope John Paul II went so far as to call torture "intrinsically evil." 1993 Encyclical, Veritatis Splendor ¶ 80 (available at http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor.html). The Catechism recalls darker times, when "cruel practices were commonly used by legitimate governments to maintain

law and order, often without protest from the Pastors of the Church." Catechism ¶ 2298. Today, "it has become evident that these cruel practices were neither necessary for public order, nor in conformity with the legitimate rights of the human person." *Id.* Thus, "regulation against the use of torture, even in the case of serious crimes, must be strictly observed [by governments]." Compendium of the Social Doctrine of the Church ¶ 404 (available at http://www.vatican.va/roman_curia/pontifical_councils/justpeace/documents/rc_pc_justpeace_doc_20060526_compendio-dott-soc_en.html) (hereinafter Compendium). The Catechism provides that torture as punishment "is contrary to respect for the person and for human dignity." Catechism ¶ 2297. As the United States Conference of Catholic Bishops noted, "[t]orture destroys our human dignity in multiple ways." United States Conference of Catholic Bishops, Torture is an Intrinsic Evil: A Catholic Study Guide for a One-Session 9 (2012) (available at http://www.usccb.org/issues-and-action/human-life-and-dignity/torture/upload/torture-is-an-intrinsic-evil-study-guide1.pdf) (hereinafter Torture Study Guide); *see also* Compendium ¶ 404 ("[T]he dignity of man is as much debased in his torturer as in the torturer's victim.").

The Church's teachings on torture are consistent with this Court's precedent. More than a century ago, this Court stated that "[p]unishments are cruel when they involve torture or a lingering death . . . ." *In re Kemmler*, 136 U.S. 436, 447 (1890); *see also Baze v. Rees*, 553 U.S. 35, 49 (2008). More recently, this Court has held that the Eighth Amendment "prohibits the imposition of inherently barbaric punishments under all circumstances." *Graham*, 560 U.S. at 59 (citing *Hope v. Pelzer*, 536 U.S. 730 (2002)). "Punishments of torture, for example, are forbidden." *Id.*

(internal quotation marks omitted) (citing *Wilkerson v. Utah*, 99 U.S. 130, 136 (1879)). The Eighth Amendment forbids "all other[] [punishments] in the same line of unnecessary cruelty." *Baze*, 553 U.S. at 48. Indeed, in upholding execution by lethal injection in *Baze*, this Court accepted that "failing a proper dose of [a barbiturate] to render the prisoner unconscious, there is a substantial, constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and pain from the injection of potassium chloride." *Id.* at 53.

The method of execution that is challenged in this case presents a "constitutionally unacceptable" specter of "torture or lingering death" that this Court warned against in *Baze* and *Kemmler*. It is undisputed that recent executions employing midazolam resulted in "lingering deaths." On July 23, 2014, Arizona inmate Joseph Wood, for example, spent an agonizing *two hours* between the administration of midazolam and hydromorphone and his death. *See* Pet. Br. at 21; Fernanda Santos, *Executed Arizona Inmate Got 15 Times Standard Dose, Lawyers Say*, N.Y. Times, Aug. 2, 2014. On April 29, 2014, it took Oklahoma inmate Clayton Lockett 43 minutes to die after he was injected with midazolam. Lindsey Bever, *Botched Oklahoma Execution Reignites Death Penalty Debate*, The Washington Post, April 30, 2014. And, on January 16, 2014, Ohio prisoner Dennis McGuire's execution lasted 25 minutes after he was administered midazolam and hydromorphone. Max Ehrenfreund, *Dennis McGuire executed in Ohio with new combination of lethal drugs*, The Washington Post, Jan. 16, 2014.

These drawn-out deaths subjected the condemned to terror and excruciating pain—not merely as an accident or

due to improper administration, but rather, as an *inherent* consequence of the use of midazolam, sometimes along with hydromorphone. Midazolam is not a barbiturate and cannot produce the coma-like unconsciousness that is required under *Baze* prior to the administration of other drugs that paralyze the diaphragm, thereby stopping respiration, and induce cardiac arrest. Its use in conjunction with other drugs, therefore, entails a "constitutionally unacceptable risk of suffocation from the administration of pancuronium bromide and of pain from the injection of potassium chloride." *Baze*, 553 U.S. at 53.

Lethal injection that causes such lingering death and pain is at odds with the Church's teachings and with this Court's precedent.

B. The Experimental Use of Midazolam in Lethal Injection Procedures Violates the Physical and Psychological Integrity of Human Beings

The recent disruptions in the supply of standard execution drugs has caused Oklahoma to turn to untested drug mixtures featuring midazolam. *See* Pet. Br. at 8-9. Some other states that used midazolam or considered using it, however, have turned away from the drug. *See id.* at 31. Midazolam is not approved for use as a sole anesthetic. *See id.* at 3. It does not reliably cause continuous, deep coma-like unconsciousness throughout the execution process. *See id.* Its use in conjunction with a paralytic and potassium chloride amounts to impermissible experimentation on human beings, which is inconsistent with the Church's teachings.

The Church rejects experimentation on human beings as immoral. The Catechism states that "[e]xperimentation on human beings is not morally legitimate if it exposes the subject's life or physical and psychological integrity to disproportionate or avoidable risks." Catechism ¶ 2295. Moreover, experimentation on humans violates "the dignity of the person if it takes place without the informed consent of the subject or those who legitimately speak for him." *Id.*

The Court has also decried experimentation on human beings. *See, e.g.*, *Rochin v. California*, 342 U.S. 165, 169 (1952) (finding that forcibly removing narcotics from a defendant's stomach—which he had swallowed when confronted by police—"offend[ed] those canons of decency and fairness which express the notions of justice of English-speaking peoples even toward those charged with the most heinous offenses") (quoting, *Malinski v. New York*, 324 U.S. 401, 417 (1945)); *United States v. Stanley*, 483 U.S. 669, 709 (1987) (O'Connor, J., concurring in part and dissenting in part) (calling experimentation on human beings without their consent "far beyond the bounds of human decency"); *id.* at 687 (Brennan, J., concurring in part and dissenting in part) (noting that "[t]he medical trials at Nuremberg in 1947 deeply impressed upon the world that experimentation with unknowing human subjects is morally and legally unacceptable"); *see also Abdullahi v. Pfizer, Inc.*, 562 F.3d 163, 180-81 (2d Cir. 2009) ("[T]he fact that the prohibition on medical experimentation on humans without consent has been consciously embedded by Congress in our law and reaffirmed on numerous occasions by the FDA demonstrates that the United States government views the norm as the source of a binding legal obligation. . . .").

The use of an untested drug to administer the most severe punishment that can be imposed on a human being is an impermissible intrusion of bodily integrity that is contrary to the Church's teachings and this Court's precedent.

C. *The Brutality of Recent Problematic Executions Devalues Human Life and Erodes Our Sense of Innate Human Dignity*

Under the Church's teachings, the rights flowing from human dignity "are prior to society and must be recognized by it." Catechism ¶ 1930. This is because "[t]he dignity of the human person is rooted in his creation in the image and likeness of God." *Id.* ¶ 1700. The "defense and promotion" of the dignity of human person "have been entrusted to us by the Creator." *Id.* ¶ 1929. Upholding this duty "entails respect for the rights that flow from [a human's] dignity as a creature." *Id.* ¶ 1930. These rights "are the basis of the moral legitimacy of every authority: by flouting them, or refusing to recognize them in its positive legislation, a society undermines its own moral legitimacy." *Id.*

> An act of such violence pushes individuals and members within a society towards two different forms of dehumanization: savagery, when feelings of anger or fear overwhelm principles of ethics and human rights; and barbarism, when perceived needs for security and supremacy destroy feelings of faith, solidarity and compassion. In fact, torture compromises the human dignity of both the victim and the perpetrator, estranging the

> torturer from God, and debasing the integrity of the tortured. What is more, when members of a society allow violent, dehumanizing practices to occur within their social sphere, that society's collective integrity and social fabric are greatly eroded. When a government not only allows, but sponsors, degrading, dehumanizing acts of violence, it sets a dangerous precedent that undermines the respect for everyone's human dignity and human rights.

Torture Study Guide at 7. Pope Benedict XVI declared that public officials should avoid "means of punishment or correction that either undermine or debase the human dignity of prisoners." Address of Pope Benedict XVI to the Participants in the Twelfth World Congress of the International Commission of Catholic Prison Pastoral Care, Sept. 6, 2007 (available at http://w2.vatican.va/content/benedict-xvi/en/speeches/2007/september/documents/hf_ben-xvi_spe_20070906_pastorale-carceraria.html).

These principles are consistent with this Court's Eighth Amendment jurisprudence. This Court has stated that the Eighth Amendment "reaffirms the duty of the government to respect the dignity of all persons." *Roper v. Simmons*, 543 U.S. 551, 560 (2005). Most recently, in striking down Florida's IQ cutoff rule for death penalty eligibility, this Court repeatedly highlighted "the Constitution's protection of human dignity." *Hall v. Florida*, 134 S. Ct. 1986, 1992 (2014); *see also id.* at 1993 (noting that executing a mentally disabled individual "contravenes the Eighth Amendment, for to impose the harshest of punishments on an intellectually disabled

person *violates his or her inherent dignity as a human being*") (emphasis added); *id.* at 2001 (noting that the law at issue "contravenes our Nation's commitment to dignity and its duty to teach human decency as the mark of a civilized world").

No matter what crimes the condemned have committed, their dignity as human beings should be respected. It offends the values of the Church, our society and the Eighth Amendment to allow unnecessary affronts to human dignity in carrying out punishment. The use of midazolam in combination with other drugs presents a substantial risk of severe physical pain and mental suffering, which undermines the dignity of the condemned, those carrying out the sentence, and all of society.

CONCLUSION

For the reasons discussed above, *amicus curiae* urges the Court to reverse the judgment below and to hold that the use of midazolam during the execution process violates the Eighth Amendment's ban on cruel and unusual punishments.

Dated: March 16, 2015

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On Writ of Certiorari
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For the Tenth Circuit

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TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES iv

INTERESTS OF AMICI CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT 8

I. OBJECTIVE INDICATORS REVEAL THE PREVAILING STANDARDS OF DECENCY 8

II. THE USE OF MIDAZOLAM IS NOT COUNTENANCED IN FORTY-SIX JURISDICTIONS. 10

A. Thirty-One Jurisdictions Either Have No Capital Punishment, Or Have No Likelihood Of Executing A Person In The Near or Distant Future 10

1. Nineteen jurisdictions have abolished capital punishment. 11

2. Four additional jurisdictions have suspended the death penalty and exhibit long-term disuse. 11

3. Three additional jurisdictions have exhibited long-term disuse and have no potential prospective use in the near or distant future. 13

4. Five additional jurisdictions use capital punishment exceedingly sparingly and have no plan to use midazolam. 14

B. Of The Twenty-One Jurisdictions That Retain and Use Capital Punishment with Some Regularity, the Vast Majority Reject Oklahoma's Experiment with Midazolam. 15

C. Even In the Jurisdictions That Permit Use of Midazolam, It Has Been Used Rarely 19

III. USE OF MIDAZOLAM TO SECURE UNCONSCIOUSNESS IN AN EXECUTION PROTOCOL CARRIES A REALIZED, ONGOING, AND INTOLERABLE RISK OF INFLICTING GRATUITOUS SUFFERING. 21

IV. OKLAHOMA'S DECISION TO ADOPT MIDAZOLAM OUT OF EXPEDIENCE IS INCONSISTENT WITH THE EVOLVING STANDARDS OF DECENCY 24

CONCLUSION 25

APPENDIX

JURISDICTIONS WITHOUT CAPITAL PUNISHMENT 1a

JURISDICTIONS WITH MORATORIUM 2a

JURISDICTIONS WITH LONG-TERM DISUSE AND NO NEAR-TERM PROSPECTIVE USE ... 3a

JURISDICTIONS WITH LONG TERM DISUSE ... 4a

JURISDICTIONS USING ONE DRUG PROTOCOL 5a

JURISDICTIONS FORMULATING A PROTOCOL 6a

JURISDICTIONS USING *BAZE* PROTOCOL 6a

JURISDICTIONS PROPOSING USE OF MIDAZOLAM 7a

JURISDICTIONS ACTUALLY USING MIDAZOLAM 7a

ENDNOTES FOR APPENDIX 8a

TABLE OF AUTHORITIES

CASES

Atkins v. Virginia, 536 U.S. 304 (2002) 9

Baze v. Rees, 553 U.S. 35 (2008) .....passim

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INTERESTS OF AMICI CURIAE[1]

The Promise of Justice Initiative (PJI) is a non-profit law office dedicated to upholding constitutional integrity. PJI addresses issues concerning the fairness of the administration of capital punishment.

The National Consensus Project (NCP) is an affiliation of scholars, researchers and lawyers dedicated to understanding the evolving standards of decency that mark a maturing society. NCP collects and provides data for use by scholars and litigators in assessing, *inter alia*, the objective indicia of society's standards, as expressed in legislative enactments and state practice. Members of the NCP have published analyses in various peer review journals, including the American Constitution Society for Law and Policy, and Cardoza Law Review.

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[1] Pursuant to this Court's Rule 37, *Amici* state that no counsel for any party authored this brief in whole or in part, and no person or entity other than *Amici* made a monetary contribution to the preparation or submission of the brief. Letters of consent by both parties were filed with the Court.

SUMMARY OF ARGUMENT

"When the law punishes by death, it risks its own sudden descent into brutality, transgressing the constitutional commitment to decency and restraint." *Kennedy v. Louisiana*, 554 U.S. 407, 420 (2008).

This Court has held that the Eighth Amendment draws its meaning from the "evolving standards of decency that mark the progress of a maturing society." *Trop v. Dulles*, 356 U.S. 86, 101 (1958). The Eighth Amendment prohibits excessive punishment, which includes a ban on methods of punishment that inflict gratuitous suffering or an inhumane death.[2] And, because the administration of a punishment is subject to human error, the Constitution also forbids methods of punishment that carry an intolerable risk of gratuitous suffering.

This case focuses on the use of the drug midazolam to secure unconsciousness in a state's death penalty protocol. There is a broad national consensus against the use of midazolam for this purpose. Only four states have experimented with the use of midazolam; only four propose using it.[3] This consensus derives from the disinclination of

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[2] *See Gregg v. Georgia*, 428 U.S. 153, 183 (1976); *In re Kemmler*, 136 U.S. 436, 447 (1890) ("Punishments are cruel when they involve torture or a lingering death . . . ").

[3] *See* Appendix, at 7a.

jurisdictions to use a protocol that carries a significant risk of causing pain and suffering.

Seven years ago, in *Baze v. Rees*, this Court traced our nation's consensus as to method of execution, from hanging, to electrocution, and finally to a three-drug lethal injection protocol involving the ultra-short-acting barbiturate sodium thiopental. 553 U.S. 35, 41–44 (2008).[4] In upholding Kentucky's lethal injection protocol, the *Baze* plurality emphasized that thirty states and the Federal Government used the same three-drug combination in their respective protocols. The Court thus found that a "broad consensus" had emerged as to the objective tolerability of the risk of gratuitous suffering inherent in Kentucky's protocol. *Id.* at 53.

The Court emphasized that the selection of the specific protocol was "motivated by a desire to find a more humane alternative" and inspired by a commitment, described by a state legislator: "[i]f we

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[4] "By the middle of the 19th century, hanging was the nearly universal form of execution in the United States. In 1888, following the recommendation of a commission empaneled by the Governor to find the most humane and practical method known to modern science of carrying into effect the sentence of death, New York became the first State to authorize electrocution as a form of capital punishment. By 1915, 11 other States had followed suit, motivated by the well-grounded belief that electrocution is less painful and more humane than hanging." *Baze*, 553 U.S. at 41–42 (quotations and citations omitted).

are going to do capital punishment, it needs to be done in the most humane manner." *Id.* at 42 n.1 (internal quotations omitted). The plurality opinion also distinguished between a risk of gratuitous suffering, as the result of an "isolated mishap," and "a hypothetical situation" in which a "series of abortive attempts" at an execution could have occurred. *Id.* at 50.

Much has changed in the seven years since this Court upheld Kentucky's execution protocol in *Baze*. First, there has been a significant decline in the use of capital punishment in the majority of states, and a growing concern about the dignity of the execution process. The risk of "a series of abortive attempts"[5] is also no longer hypothetical.[6]

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[5] *State of La. ex rel. Francis v. Resweber*, 329 U.S. 459, 471 (1947) (Frankfurter, J., concurring).

[6] Following this Court's decision in *Baze*, in 2009, Ohio tried unsuccessfully to execute Romell Broom. After two hours and eighteen attempts to set an IV line, the governor issued a temporary reprieve. *See Reynolds v. Strickland*, 583 F.3d 956, 957 (6th Cir. 2009) (Cole, J., concurring) (noting the "eighteen unsuccessful efforts to run an intravenous line into Romell Broom's veins over the course of two hours"). Additionally, prison officials called off the execution of Clayton Lockett who had initially been declared to be unconscious and then exhibited clear signs of consciousness; Mr. Lockett died forty-three minutes later. Erik Eckholm & John Schwartz, *Timeline Describes Frantic Scene at Oklahoma Execution*, N.Y. TIMES, May 1, 2014, *available at* http://www.nytimes.com/2014/05/02/us/oklahomaofficialcalls-for-outside-review-of-botched-execution.html.

An outlier handful of states have experimented with the use of midazolam—a drug not part of the three-drug protocol upheld in *Baze*. These experiments have produced undignified results in Arizona, Ohio, and Oklahoma.[7]

Arizona and Ohio have since changed their protocols.[8] Other states that had previously authorized the use of midazolam also abandoned it after the executions of Dennis McGuire (Ohio),

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[7] *See Warner v. Gross*, 135 S. Ct. 824 (2015) (Sotomayor, J., dissenting) ("Lockett awoke and writhed on the execution table for some time after the drugs had been injected ."). *See also id.* at 827 ("Likewise, in Arizona's July 23, 2014, execution of Joseph Wood, the condemned inmate allegedly gasped for nearly two hours before dying, notwithstanding having been injected with the drug hydromorphone and 750 milligrams of midazolam "); Erica Goode, *After a Prolonged Execution, Questions Over 'Cruel and Unusual,'* N.Y. TIMES, Jan. 18, 2014, at A12 (noting that McGuire made "gasping, snorting and choking sounds" over the course of twenty-five minutes).

[8] Arizona has retained one-drug protocols using pentobarbital or thiopental and removed a two-drug protocol using midazolam, while adding a three-drug protocol using thiopental or, as a last resort, midazolam. Letter from Charles Ryan, Director, Arizona Dept. of Corr., to Janice Brewer, Arizona Governor (Dec. 22, 2014), *available at* corrections.az.gov/sites/default/files/documents/PDFs/letter_to_governor_brewer.pdf. Ohio has removed midazolam from its protocol and has postponed all executions. Press Release, Ohio Dept. of Rehabilitation and Correction, Ohio Revises Lethal Injection Protocol (Jan. 8, 2015), *available at* drc.ohio.gov/Public/press/press436.htm.

Clayton Lockett (Oklahoma), and Joseph Wood (Arizona).[9] Oklahoma, however, seeks to continue to use midazolam in its three-drug protocol.

Unlike in *Baze*, there is no broad national consensus that supports Oklahoma's position that the use of midazolam entails a tolerable risk of gratuitous suffering. Indeed, the broad consensus is against the use of experiment with midazolam. Oklahoma is one of only two states—Florida is the other—where a condemned inmate faces a reasonable likelihood of being executed with a protocol that includes midazolam. Several other states have contemplated using midazolam, but each has either withdrawn its protocol or identified alternate protocols to ensure the execution is not unnecessarily cruel or unusual. As such, in forty-six states, and also in the District of Columbia and in the Federal system, midazolam is unlikely to play a role in future executions.

The already realized and ongoing intolerable risk of gratuitous suffering, along with broad consensus of states that resist using midazolam because of its risk of gratuitous suffering, warrants invalidation of Oklahoma's execution protocol. But

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[9] *See, e.g.*, Associated Press, *Kentucky Drops 2-Drug Executions, Reworking Method*, WLWT 5, Nov. 14, 2014, *available at* http://www.wlwt.com/news/kentucky-drops-2drug-executions-reworking-method/29716428 (stating that "prosecutors cited 'recent events in other states'" as the reason for removing the midazolam protocol).

these are perhaps not the most disquieting aspects of Oklahoma's protocol: the available evidence gives at least the appearance that the state persists with its use of midazolam not because careful deliberation has led its officials to believe that midazolam is humane, but instead because using midazolam is expedient. This Court should invalidate Oklahoma's execution protocol and hold that the risk of gratuitous suffering inherent in the use of midazolam is intolerable.

ARGUMENT

I. OBJECTIVE INDICATORS REVEAL THE PREVAILING STANDARDS OF DECENCY.

Objective indicators aid the Court's effort to determine whether a punishment practice or method is consistent with contemporary standards of decency. In *Roper v. Simmons*, for example, the Court counted 30 states that rejected the death penalty for juvenile offenders—"12 that ha[d] rejected it altogether and 18 that maintain[ed] it but, by express provision or judicial interpretation, exclude[d] juveniles from its reach." *Roper v. Simmons*, 543 U.S. 551, 564 (2005). *See also Kennedy v. Louisiana*, 554 U.S. 407, 422 (2008) (noting the consistent approach of measuring the objective indicia of consensus).

The Court has also rejected the death penalty for intellectually disabled offenders after detecting a national consensus against the practice. *See Atkins v. Virginia*, 536 U.S. 304, 316 (2002). In addition to the 30 states that had formally barred the death penalty at the time of *Atkins*—either generally or specifically for the intellectually disabled—the Court also noted states like New Hampshire and New Jersey: though such states "continue[d] to authorize executions," neither one had performed an execution in decades, which meant "there [was] little need to pursue legislation barring the execution of the mentally retarded in those States." *Id. See also Kennedy v. Louisiana*, 554 U.S. at 433 ("There are measures of consensus

other than legislation. Statistics about the number of executions may inform the consideration whether capital punishment for the crime of child rape is regarded as unacceptable in our society.").

Most recently, in *Hall v. Florida*, 134 S. Ct. 1986 (2014), the Court also indicated that long-term disuse coupled with executive action counted against the permissibility of a challenged punishment practice. *Id.* at 1997 (placing "on the abolitionist side of the ledger" the "18 States that have abolished the death penalty, either in full or for new offenses, and Oregon, which has suspended the death penalty and executed only two individuals in the past 40 years."). In each of these opinions, the Court recognized that the risk of cruel and unusual punishment was sufficient to warrant prohibiting the execution of an entire class.[10]

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[10] In *Simmons*, *Atkins*, and *Hall*, the Court recognized that not all juvenile or all intellectually disabled offenders had diminished culpability in a way that required exemption from execution; rather, in each instance, the Court recognized that the *risk* of executing individuals in a manner that was cruel and unusual required exemption of the entire class. For example, in *Simmons*, the Court interpreted the consensus against the juvenile death penalty to flow not necessarily from the rigid belief that no juvenile could ever possess sufficient culpability to warrant a death sentence, but rather as a marker that society cannot tolerate the risk that "a youthful person" might "receive the death penalty despite insufficient culpability." *Id.* at 572–73.

II. THE USE OF MIDAZOLAM IS NOT COUNTENANCED IN FORTY-SIX STATES.

Reviewing the "objective indicia of society's standards, as expressed in legislative enactments and state practice with respect to executions," *Kennedy*, 554 U.S. at 408, reveals a growing resistance to the risk of cruel and unusual punishment in the form of a drug protocol utilizing midazolam.

Of the fifty-two jurisdictions in the United States (fifty states, the District of Columbia, and the Federal government), there is no reasonable likelihood that an execution involving midazolam will occur in forty-six states.[11] The District of Columbia, and the Federal system also reject the use of midazolam. These decisions are strong "objective indicia of consensus." There are fewer than five jurisdictions in which midazolam might realistically be used in an execution.

A. Thirty-One Jurisdictions Either Have No Capital Punishment, Or Have No Likelihood Of Executing A Person In The Near or Distant Future

Thirty-one jurisdictions have either abolished capital punishment, suspended the death penalty, or have no likelihood of execution in the

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[11] The information identified in this section relevant to state protocols is placed in the Appendix, attached to this brief for ease of reference.

near to distant future. None of these jurisdictions contemplate using midazolam.

1. Nineteen jurisdictions have abolished capital punishment.

Eighteen states[12] plus the District of Columbia have abolished the death penalty. Six of these states have abolished capital punishment in the past eight years: New Jersey (2007), New York (2007), New Mexico (2009), Illinois (2011), Connecticut (2012), Maryland (2013),[13] and four of these have done so since *Baze*.

2. Four additional jurisdictions have suspended the death penalty and exhibit long-term disuse.

Four additional jurisdictions have moratoria in place, suspending use of the death penalty, and a long history of disuse consistent with the measure the Court used in *Hall*. As the Court observed in *Hall,* states that have suspended use of the death

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[12] See Appendix at 1a noting abolition in Alaska, Connecticut, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, North Dakota, Rhode Island, Vermont, West Virginia, and Wisconsin.

[13] Of those six states, only New Mexico and Connecticut still have individuals on death row. Neither of those states proposes to use midazolam in any future executions that may occur. See Appendix 1a & endnote **Error! Bookmark not defined.**, **Error! Bookmark not defined.**.

penalty, coupled with long term disuse are similar to those that have abolished the punishment. *Id.* at 1997 (placing "on the abolitionist side of the ledger" "Oregon, which has suspended the death penalty and executed only two individuals in the past 40 years.").

The growing concern over the ability of States to humanely execute condemned offenders has contributed to formal moratoriums in four states: Colorado,[14] Oregon, Pennsylvania, and Washington.[15]

Colorado has executed one individual since 1967. Oregon has executed two individuals since 1962. Pennsylvania has executed only three

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[14] Governor Hickenlooper, when explaining his moratorium on executions in Colorado, specifically referenced the botched execution of Clayton Lockett (which used midazolam) in Oklahoma: "This is the kind of thing that a number of people, not everyone, but a number of people . . will stop, think about it, and maybe people will change their opinions." *See* Whitney Wild, *Governor, DA weigh in on botched execution*, 9 NEWS, Apr. 30, 2014, *available at* http://www.9news.com/story/news/local/2014/05/01/governor-da-weigh-in-on-botched-execution/8549209/. *See also* Mike Littwin, *The Rush To More Botched Executions*, THE COLORADO INDEPENDENT, May 2, 2014, *available at* http://www.coloradoindependent.com/147293/littwin-the-rush-to-more-botched-executions ("Now we can understand why John Hickenlooper decided to grant Nathan Dunlap his temporary reprieve last year.").

[15] *See* Appendix at 2a.

individuals since 1962; each was a volunteer. Washington has executed five individuals since 1963.[16]

3. Three additional jurisdictions have exhibited long-term disuse and have no potential prospective use in the near or distant future.

Three additional states—New Hampshire, Wyoming, and Kansas—exhibit a long-term disuse of capital punishment, coupled with an exceedingly rare prospect of future executions.

Though it retains the death penalty by statute, New Hampshire has not performed an execution in 86 years; it has only one occupant on the death row, and that case has yet to complete direct appellate review. Wyoming has executed one person in the last 50 years, and its death row is empty. Kansas, as the *Hall* Court noted, "has not had an execution in almost five decades." *Hall*, 134 S. Ct. at 1997. Indeed, since adopting its current

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[16] All data concerning the date of last execution and the number of executions is drawn from The Espy File, which catalogs all executions in the United States between 1608 and 2002. M. Watt Espy & John Ortiz Smykla, *Executions in the United States, 1608–2002: The ESPY File*, DEATH PENALTY INFO. CTR., *available at* www.deathpenaltyinfo.org/documents/ESPYstate.pdf. Counsel also draws from the searchable database for all executions between 1976 and the current date. *Executions in the U.S. 1608–2002*, DEATH PENALTY INFO. CTR., *available at* www.deathpenaltyinfo.org/views-executions.

capital punishment statute in 1994, no death sentence has survived Kansas's initial appellate review.[17]

4. Five additional jurisdictions use capital punishment exceedingly sparingly and have no plan to use midazolam.

Five additional states—Idaho, Kentucky, Montana, Nebraska, and South Dakota—have performed only three executions each over the past 50 years. The lack of use in these states is similar, but not quite as strong, as the lack of use that the Court described in *Hall*, when discussing Kansas. Of the fifteen executions that these five states have performed, more than one-third (6 of 15) have involved inmates who withdrew their appeals and volunteered for execution.[18] Executions in these states are exceedingly rare. None of these states

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[17] None of these states contemplate using midazolam. Kansas and New Hampshire have no lethal injection protocol; Wyoming has promulgated a three-drug protocol but does not propose using midazolam. *See* Appendix at 3a.

[18] There have been only been three contested executions total in these five states in the last fifteen years. See Appendix at 4a noting each of the executions in these states and which executions occurred as a result of the condemned inmates decision to volunteer for execution (noted by a (V) in the appendix.)

have ever executed someone using midazolam, and none plan to execute an inmate with midazolam.[19]

In sum, thirty-one jurisdictions (thirty states and the District of Columbia) have either abolished the death penalty or have moratorium in place, and/or execute individuals exceedingly rarely. None of these jurisdictions provide evidence to support use of midazolam; all of these jurisdictions support the consensus that midazolam should not be used in an execution protocol.

B. Of The Twenty-One Jurisdictions That Retain and Use Capital Punishment with Some Regularity, the Vast Majority Reject Oklahoma's Experiment with Midazolam.

Of the twenty-one jurisdictions that use capital punishment, seventeen jurisdictions do not currently have a protocol that uses midazolam. Eight have adopted a one-drug protocol that does

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[19] Idaho proposes a one-drug protocol using a three drug protocol using sodium penthol, or a two drug protocol using pentobarbital, or a one drug protocol using siodium pentothal or pentobarbital. See Appendix at 12a. n.27. Kentucky, while technically still appearing to have midazolam in its protocol, has specifically disavowed use of midazolam after the botched execution in Oklahoma. Id at n.28.. Montana proposes a two-drug protocol using pentobarbital and a paralytic. Id. at n. 29. Nebraska proposes a three-drug protocol using thiopental rather than midazolam. Id. at n. 30. South Dakota proposes a two-drug protocol using thiopental and a paralytic. Appendix at 13a n. 31.

not include midazolam: Arizona, Georgia, Missouri,[20] North Carolina, Ohio,[21] Tennessee, Texas, and Utah.[22] Five jurisdictions—Arkansas, California, Louisiana,[23] Nevada, and the Federal

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[20] Missouri administers midazolam, but as a pre-execution treatment for anxiety in line with – whatever the legal propriety -- its clinical use. *See* Chris McDaniel, *Missouri Uses Midazolam in its Most Recent Execution*, ST. LOUIS PUB. RADIO, Jan. 22, 2015, *available at* http://news.stlpublicradio.org/post/missouri-used-midazolam-its-most-recent-execution.

[21] Ohio stopped using midazolam after a series of botched executions. *See* Mark Berman, *Ohio Drops Controversial Lethal Injection Drug, Postpones Upcoming Execution*, THE WASHINGTON POST, Jan. 9. 2015 ("Ohio announced this week that it will no longer execute inmates with lethal injection drugs that were involved in two bungled executions last year, a change that will delay at least one execution and possibly others scheduled for this year.").

[22] *See* Appendix at 5a. In addition, Idaho and Washington, mentioned in Section III (B), have also adopted a one-drug protocol.

[23] In 2014, the Louisiana Legislature enacted a Department of Corrections led Commission to "study and make recommendations relative to the different forms of execution and the method of execution to determine the best practices for administering the death penalty in the *most humane manner*." *See* LA LEGIS H.R. 142 (2014), 2014 La. Sess. Law Serv. Hs. Res. 142 (WEST). The Report on Study of Methods of Execution & Recommendations for Procedures was issued by the Louisiana Dept. of Public Safety and Corrections on February 18, 2015. The report recommends utilizing a one-drug protocol of 5 gm of pentobarbital, and also recommends that the legislature consider nitrogen hypoxia as an alternate method. Della Hasselle, *Death Penalty Study Suggests Using*

Government—are in the process of formulating a protocol.[24] Four more jurisdictions—Delaware, Indiana, Mississippi, and South Carolina—have proposed using the three-drug protocol upheld in *Baze*.[25]

Only four states—Oklahoma, Florida, Alabama, and Virginia—have protocols in place that realistically propose using midazolam.[26] Of these four states, only Oklahoma and Florida have ever used the protocol.[27]

Nitrogen to Carry Out Executions, THE LENS, Mar. 4, 2014. *available at* http://thelensnola.org/2015/03/04/death-penalty-study-suggests-using-nitrogen-to-carry-out-executions/ (discussing DPSC recommendations to legislature of adopting nitrogen hypoxia method).

[24] *See* Appendix at 6a. Kansas, New Hampshire, Oregon, and Kentucky, discussed *supra*, Section III (B), are also in the process of developing a new protocol.

[25] Though they differ on whether to use thiopental or pentobarbital for the purpose of securing unconsciousness, none of these last four states use midazolam as part of their protocol.

[26] *See* Appendix at 7a. Arizona has a protocol in place that still allows for the use of midazolam, but only as an alternative to viable other options and as a last resort.

[27] Virginia and Alabama have proposed using midazolam as the first drug in a three-drug protocol but have not yet used the protocol. While amici counts Virginia and Alabama with Oklahoma and Florida for purposes of assessing whether a national consensus against the use of midszolam exists, there

In *Kennedy v. Louisiana*, the Court stated, "[t]hough our review of national consensus is not confined to tallying the number of States with applicable death penalty legislation, it is of significance that, in 45 jurisdictions, petitioner could not be executed for child rape of any kind." 554 U.S. at 426. The Court observed: "The evidence here bears a closer resemblance to the evidence of state activity in *Enmund*, where we found a national consensus against the death penalty for vicarious felony murder despite eight jurisdictions having authorized the practice." *Id.* at 433. Here, no matter how the states are tallied,[28] only four currently have protocols that could reasonably result in the use of midazolam in an execution.

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is no certainty that they will use the protocol. *Cf Kennedy v. Louisiana*, 554 U.S. at 431 ("It is not our practice, nor is it sound, to find contemporary norms based upon state legislation that has been proposed but not yet enacted. There are compelling reasons not to do so here. Since the briefs were submitted by the parties, legislation in two of the five States has failed.").

[28] In *Kennedy v. Louisiana*, where the parties disagreed whether there were four states that authorized capital punishment for non-homicide offenses, *id.* at 424 (Petitioner claiming that Georgia would not count), or six such states, *id.* (Respondent claiming that Florida would count), the Court explained that "[d]efinitive resolution of state-law issues is for the States' own courts, and there may be disagreement over the statistics," *id.* at 425.

C. Even In the Jurisdictions That Permit Use of Midazolam, It Has Been Used Rarely

The objective indicia reflected in executions reveal that the evolving standards of decency reserve use of the death penalty in a humane manner.

Not only is the presence of midazolam in current protocols minimal, the usage of midazolam is exceedingly rare. "There are measures of consensus other than legislation. Statistics about the number of executions may inform the consideration whether [the challenged punishment] is regarded as unacceptable in our society." *Kennedy v. Louisiana*, 554 U.S. at 433.

The objective indicia clearly establish a national consensus. Only fifteen people have been executed with midazolam. While four were visibly problematic, there is a heightened risk that in the remaining eleven executions midazolam did not prevent pain and suffering by producing a deep unconsciousness; rather there is a significant risk that midazolam's failure to produce deep unconsciousness was masked by a paralytic agent that simultaneously caused severe and inhumane pain.

Based upon these inhumane results, Ohio and Arizona have ceased using midazolam. Other states, such as Colorado and Kentucky, at one point had midazolam in their protocols but have now

disavowed its use. Louisiana had similarly offered midazolam as an alternative method, but the Legislature created a study commission on the issue after the Oklahoma botched execution and recommended against its use

Indeed, while midazolam has been readily available for the last five years, the vast majority of jurisdictions—including California, Arkansas, North Carolina, and the Federal government—have preferred caution rather than the undertaking the risk of intolerable pain and suffering.

III. USE OF MIDAZOLAM TO SECURE UNCONSCIOUSNESS IN AN EXECUTION PROTOCOL CARRIES A REALIZED, ONGOING, AND INTOLERABLE RISK OF INFLICTING GRATUITOUS SUFFERING.

Midazolam was not one of the drugs in the *Baze* protocol. The protocol that the Court considered in *Baze* contained three drugs: sodium thiopental, an ultra-fast-acting barbiturate sedative that induces a "deep, comalike [sic] unconsciousness;" pancuronium bromide, a paralytic agent that prohibits muscle movement and quiets breathing; and potassium chloride, which causes cardiac arrest. *Baze v. Rees*, 553 U.S. 35, 43–44 (2008). Though the *Baze* petitioners feared that Kentucky's three-drug protocol could result in gratuitous suffering, the prospect of that suffering was based on maladministration rather than risks inherent in the drugs themselves. *Id.* at 62. The condemned in *Baze* proposed a one-drug protocol that a number of states have now adopted. *Id.* at 55.

Four states have neither adopted the one-drug protocol nor adhered to the *Baze* protocol. Alabama, Virginia, Oklahoma, and Florida substitute the benzodiazepine drug midazolam for the barbiturate sodium thiopental.[29]

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[29] *See* Appendix at 7a. Two additional states—Arizona and Ohio—have previously used midazolam in a two-drug protocol

Baze explained that sodium thiopental, when properly administered, "ensures that the prisoner does not experience any pain associated with the paralysis and cardiac arrest caused by the second and third drugs." *Id.* at 44. The problem with substituting midazolam for sodium thiopental is that midazolam cannot reliably induce the desired deep, coma-like unconsciousness. In other words, it does not reliably prevent "the pain associated with the paralysis and cardiac arrest." *Id.*

Petitioner's *Brief* outlines the series of what can only be described as botched or undignified executions involving midazolam. Here, amici avoids the spectacle of recounting these executions but notes that the nation watched as several experiments with midazolam executions failed in 2014: first in Ohio, then Oklahoma, and finally in Arizona. In Ohio, Dennis McGuire gasped, choked, clenched his fists, and appeared to struggle against his restraints for ten to fifteen minutes after being injected with midazolam and hydromorphone.[30] Then, in Oklahoma, Clayton Lockett grimaced and tensed his body several times over a three-minute period before officials lowered the blinds. After

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along with the opioid hydromorphone. Both appear to have discontinued that protocol.

[30] *See* Erica Goode, *After a Prolonged Execution in Ohio, Questions over 'Cruel and Unusual,'* N.Y. TIMES, Jan. 17, 2014, *available at* http://www.nytimes.com/2014/01/18/us/prolonged-execution-prompts-debate-over-death-penalty-methods.html

being declared unconscious ten minutes into the process, Lockett spoke at three separate moments. He was announced dead thirty minutes later.[31] Finally, in Arizona, Joseph Wood gasped 660 times over a two-hour period before he was declared dead.[32]

In response to the Lockett execution, the President directed the Attorney General to review the state and federal process.[33]

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[31] *See* Eric Eckholm, *One Execution Botched, Oklahoma Delays the Next*, N.Y. TIMES, Apr. 29, 2014, *available at* http://www.nytimes.com/2014/04/30/us/oklahoma-executions.html.

[32] *See* Erik Eckholm, *Arizona Takes Nearly 2 Hours to Execute Inmate*, N.Y. TIMES, Jul. 23, 2014, *available at* http://www.nytimes.com/2014/07/24/us/arizona-takes-nearly-2-hours-to-execute-inmate.html.

[33] The New York Times noted that "President Obama declared this week's botched execution in Oklahoma 'deeply disturbing' and directed the attorney general on Friday to review how the death penalty is applied in the United States at a time when it has become increasingly debated." Peter Baker, *Obama Orders Policy Review on Executions*, N.Y. TIMES, May 3, 2014, *available at* http://www.nytimes.com/2014/05/03/us/flawed-oklahoma-execution-deeply-troubling-obama-says.html.

IV. OKLAHOMA'S DECISION TO ADOPT MIDAZOLAM OUT OF EXPEDIENCE IS INCONSISTENT WITH THE EVOLVING STANDARDS OF DECENCY

The adoption of Oklahoma's execution protocol is concerning because it appears that expediency—and not careful deliberation—drove the inclusion of midazolam in the state's three drug protocol. The *Baze* opinion observed that the state's purpose in adopting the protocol was borne out of "a desire to find a more humane alternative." *Baze*, 553 U.S. at 42 n.1. Here, however, Oklahoma's decision to use midazolam fits more closely with an expediency narrative than it does a narrative of careful, thoughtful deliberation. As noted by Justice Sotomayor, dissenting from the denial of a stay of execution in this case, Oklahoma's expert "appeared to rely primarily on the web site www.drugs.com" in forming his opinion that the protocol would work. *Warner v. Gross*, 135 S. Ct. 824, 827 (2015) (Sotomayor, J., dissenting).

"When the law punishes by death, it risks its own sudden descent into brutality, transgressing the constitutional commitment to decency and restraint." *Kennedy*, 554 U.S. at 420. The choice of execution protocol based upon *expedience* reflects an undignified response to the challenging question of how the government administers capital punishment. The constitution requires that where capital punishment is imposed, it be implemented in a humane manner.

The vast majority of jurisdictions take steps to ensure that capital punishment is administered humanely. Oklahoma's experimental method neither reflects the national approach to capital punishment as it has been nor as we would want it to be. *See Hall*, 134 S. Ct. at 1992 (explaining that "[t]he Eighth Amendment's protection of dignity reflects the Nation we have been, the Nation we are, and the Nation we aspire to be.").

CONCLUSION

For the forgoing reasons, amici respectfully suggest that the Court reject Oklahoma's experimental protocol.

Respectfully submitted,

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JURISDICTIONS WITHOUT CAPITAL PUNISHMENT

State	Date of Abolition
Mich. [1]	1847
Wis. [2]	1853
Me. [3]	1887
Minn. [4]	1911
Alaska [5]	1957
Haw. [6]	1957
Iowa [7]	1965
W Va. [8]	1965
Vt. [9]	1972
N.D. [10]	1973
D.C. [11]	1981
Mass. [12]	1984
R.I. [13]	1984
N.J. [14]	2007
N.Y. [15]	2007
N.M. [16]	2009
Ill. [17]	2011
Conn. [18]	2012
Md. [19]	2013

JURISDICTIONS WITH MORATORIUM

State	Date of Morato-rium	Status of Current Protocol	Date of Last Executions
Colo. [20]	5/22/2013	3-drug sodium thiopental	**2/06/1967** 10/13/97
Or. [21]	11/22/2011	No valid protocol in place.	**8/20/1962** 5/16/97 (V) 9/06/96 (V)
Pa. [22]	2/15/2015	(1) 3-drug pentobarbital or (2) 3-drug sodium thiopental	**2/4/1962** 5/02/95 (V) 8/15/95 (V) 7/06/99 (V)
Wash. [23]	2/11/ 2014	(1) 3-drug pentobarbital or (2) 3-drug sodium thiopental	**6/20/1963** 1/05/93 (V) 5/27/94 10/13/98 8/21/01 (V) 9/10/10

JURISDICTIONS WITH LONG-TERM DISUSE AND NO NEAR-TERM PROSPECTIVE USE

State	Number of people on death row	Status of Current Protocol	Date of Last Executions
Kan.[24]	10 (0)	No valid protocol in place.	**6/22/1965**
N.H.[25]	1 (0)	2-drug protocol.	**7/14/1939**
Wyo.[26]	0	No valid protocol in place.	**10/12/1965** 10/12/1965 1/22/1992

JURISDICTIONS WITH LONG TERM DISUSE

State	Number of people on death row	Status of Current Protocol	Date of Last Executions
Idaho [27]	11	3-drug protocol	**10/18/1957** 1/06/1994 (V) 11/18/2011 6/12/2012
Ky.[28]	35	No operational protocol.	**2/3/1962** 7/19/1997 5/25/1999 (V) 11/21/2008 (V)
Mont. [29]	2	2-drug protocol not currently operational.	**9/10/1943** 5/10/1995 2/24/1998 8/11/2006 (V)
Neb.[30]	11	3-drug protocol not currently operational	**6/25/1959** 9/02/1994 7/17/1996 12/02/197
S.D.[31]	3	3-drug protocol with 1- drug protocol alternative.	**8/4//1947** 7/11/2007 (V) 10/15/2012 (V) 10/30/2012

JURISDICTIONS USING ONE DRUG PROTOCOL

State	Status of Current Protocol
Ariz. [32]	(1) 1-drug pentobarbital; (2) 1-drug sodium thiopental; (3) 3-drug incl. sodium thiopental; or (4) 3-drug incl. midazolam
Ga. [33]	1-drug pentobarbital
Mo. [34]	5 g pentobarbital
N.C. [35]	5 g pentobarbital
Oh. [36]	5 g pentobarbital or 5 g thiopental sodium
Tenn. [37]	1-drug pentobarbital
Tex. [38]	1-drug pentobarbital
Utah [39]	1-drug sodium thiopental

JURISDICTIONS FORMULATING A PROTOCOL

State	Status of Current Protocol
Ark. [40]	Method of Execution Ac t is under judicial review.
Cal. [41]	State has stopped defending previous 3-drug protocol.
La. [42]	Method of execution is under legislative consideration; prior 1-drug protocol under separate judicial review.
Nev. [43]	Prison where executions are performed has closed, unclear how many usable drugs remain.
Fed. [44]	Protocol still undergoing review.

JURISDICTIONS USING *BAZE* PROTOCOL

State	Status of Current Protocol
Del. [45]	3-drug protocol using sodium thiopental; or 3-drug protocol using pentobarbital
Ind. [46]	3-drug protocol using sodium thiopental
Miss. [47]	3 drug protocol using 2 g pentobarbital, 50 mg pavulon, 50 mEq potassium chloride
S.C. [48]	3-drug protocol using pentobarbital

JURISDICTIONS PROPOSING USE OF MIDAZOLAM

State	Status of Current Protocol
Va. [49]	(1) 3-drug protocol incl. midazolam, (2) 3-drug protocol incl. pentobarbital, or (3) 3-drug protocol incl. sodium thiopental
Ala. [50]	500 mg midazolam; 600 mg procuronium bromide; 240 mEq potassium chloride

JURISDICTIONS ACTUALLY USING MIDAZOLAM

State	Status of Current Protocol
Okla. [51]	50 mg midazolam and 50 mg hydromorphone, 100 mEq potassium chloride; or 100 mg midazolam, 40 mg vecuronium bromide, 200 mEq potassium chloride
Fla. [52]	500 mg midazolam; 100 mg vecuronium bromide; 240 mEq potassium chloride

ENDNOTES FOR APPENDIX

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[1] Michigan has not had the death penalty since 1847. *See* www.deathpenaltyinfo.org/states-and-without-death-penalty.

[2] Wisconsin has not had the death penalty since 1853. Id.

[3] Maine has not had the death penalty since 1887. Id.

[4] Minnesota has not had the death penalty since 1911. Id.

[5] Alaska has not had the death penalty since 1957. Id.

[6] Hawaii has not had the death penalty since 1957. Id.

[7] Iowa has not had the death penalty since 1965. Id.

[8] West Virginia has not had the death penalty since 1965. Id.

[9] Vermont has not had the death penalty since 1972. Id.

[10] North Dakota has not had the death penalty since 1973. Id.

[11] The District of Columbia has not had the death penalty since 1981. Id.

[12] Massachusetts has not had the death penalty since 1984. Id.

[13] Rhode Island has not had the death penalty since 1984. Id.

[14] New Jersey has not had the death penalty since 2007. Id.

[15] New York has not had the death penalty since 2007. Id.

[16] New Mexico has not had the death penalty since 2009. Id. It has no protocol in place.

[17] Illinois has not had the death penalty since 2011. Id. A moratorium was imposed in 2000 and all subsequent death sentences commuted; last execution 3/17/99. John Schwartz, *Illinois Governor Signs Capital Punishment Ban*, NY TIMES, Mar. 9, 2011 (*available at* www.nytimes.com/2011/03/10/us/10illinois.html); Cornelia Grumman and Rick Pearson, *Ryan Agonized, But Confident He 'Did the Right Thing,'* CHICAGO TRIBUNE, Mar. 18, 1999 (*available at* articles.chicagotribune.com/1999-03-18/news/9903180130_1_case-of-anthony-porter-penalty-lorraine-borowski).

[18] Connecticut abolished the death penalty in 2012. State of Connecticut, Governor Dannel P. Malloy, *Gov. Malloy on Signing Bill to Repeal Capital Punishment*, Apr. 25, 2012 (*available at* www.governor.ct.gov/malloy/cwp/view.asp?A=4010&Q=503122). The bill provides for prospective repeal only. A protocol for execution remains in place providing for: 2,500 mg thiopental sodium; 100 mg pancuronium bromide: 120 mEq potassium chloride State of Connecticut, Department of Correction, Administrative Directive No. 6.15: Administration of Capital Punishment, Attachment A, May 14, 2014 (*available at* www.ct.gov/doc/LIB/doc/PDF/AD/ad0615.pdf).

[19] Maryland abolished the death penalty in 2013. *See* Associated Press, *Maryland: Governor Signs Repeal of the Death Penalty*, N.Y. TIMES, May 2, 2013 (*available at* www.nytimes.com/2013/05/03/us/maryland-governor-signs-repeal-of-the-death-penalty.html); Alan Binder, *Life Sentences for Last Four Facing Death in Maryland*, N.Y. TIMES, Dec. 31, 2014 (*available at* www.nytimes.com/2015/01/01/us/maryland-governor-omalley-commutes-death-sentences-emptying-death-row.html).

[20] Office of the Governor, Executive Order D 2013-006: Death Sentence Reprieve, May 22, 2013, (*available at*

www.scribd.com/doc/143073608/Hickenlooper-Death-Sentence-Reprieve-for-Nathan-Dunlap) (granting temporary reprieve to death row prisoner, in part because the state was "not immediately equipped to carry out a death sentence" and "[r]ecent restrictions imposed by pharmaceutical companies and the Food and Drug Administration make procuring these drugs challenging."). The protocol in place provides for use of sodium pentothol, pancuronium bromide, and potassium chloride. Colorado Department of Corrections, *Execution Day* (undated) (*available at* www.doc.state.co.us/execution-day) (referring to "Department's lethal injection procedures, which provides the delivery of a lethal solution of sodium pentothol, pancuronium bromide, and potassium chloride.").

[21] Helen Jung, *Gov. John Kitzhaber Stops Executions in Oregon, Calls System 'Compromised and Inequitable'*, THE OREGONIAN, Nov. 22, 2011 (*available at* www.oregonlive.com/pacific-northwest-news/index.ssf/2011/11/gov_john_kitzhaber_stops_all_e.html). The legislature has provided a means of lethal injection. See ORS 137.473: *Means of Inflicting Death* (specifying "ultra-short-acting barbiturate in combination with a chemical paralytic agent and potassium chloride or other equally effective substances sufficient to cause death" but not identifying a specific barbiturate).

[22] Press Release, Governor Tom Wolf Announces a Moratorium on the Death Penalty in Pennsylvania, Feb. 13, 2015 (*available at* www.governor.pa.gov/Pages/Pressroom_details.aspx?newsid=1566#.VQCp4vnF98E). *See also* Associated Press, *Pennsylvania Governor Imposes Moratorium on Death Penalty*, N.Y. TIMES, Feb. 13, 2015. The protocol in place in Pennsylvania provides for a three-drug protocol consistent with the *Baze* protocol. *Chester v. Wetzel*, No. 08-1261, 2015 WL 632374, at *2 (M.D. Pa. Feb. 13. 2015) ("The protocol calls for the injection of three drugs in order to effectuate execution of the prisoner. The first drug injected into the prisoner will be either 5,000 mg of pentobarbital or 3 gm sodium

thiopental. Half of this first drug will be injected into the left arm, and the other half will be injected into the right arm.").

[23] Ian Lovett, *Executions are Suspended by Governor in Washington*, NY TIMES, Feb. 11, 2014. The protocol still provided precludes the use of midazolam. State of Washington, Dept. of Corrections, Policy No. DOC 490.200 "Capital Punishment," § (IX)(A)(4)(d) (*available at* www.doc.wa.gov/policies/showFile.aspx?name=490200).

[24] All of the data concerning dates of execution derive from *The Espy File, Executions in the U.S. 1608-2002: Executions by State*, located at www.deathpenaltyinfo.org/documents/ESPYstate.pdf and the searchable database of executions located at www.deathpenaltyinfo.org/views-executions (hereinafter "*Espy File*"). The method of execution in Kansas is prescribed by statute. *See* KS C. Cr. P. § 22-4001 (stating that "[t]he mode of carrying out a sentence of death in this state shall be by intravenous injection of a substance or substances in a quantity sufficient to cause death in a swift and humane manner" but not specifying any substances). None of the cases involving the condemned inmates have proceeded past an initial appellate review.

[25] *Espy File*, *supra* n.25. The method of execution in New Hampshire is prescribed by statute. N.H. Criminal Code. Title LXII, Ch. 630, § 630:5 Procedure in Capital Murder, Subsections XIII-XIV (referring to "continuous, intravenous administration of a lethal quantity of an ultra-short-acting barbiturate in combination with a chemical paralytic agent;" alternative of hanging). The single case involving a condemned inmate has not proceeded past appellate review.

[26] *Espy File*, *supra* n.25. The method of execution in Wyoming is prescribed by statute. Wyo. Stat. § 7-13-904. Method of execution ("(a) When sentence of death is imposed by the court in any criminal case, the punishment of death shall be executed by the administration of a continuous intravenous injection of a lethal quantity of an ultra-short-acting

barbiturate, alone or in combination with a chemical paralytic agent and potassium chloride, or other equally effective substance or substances sufficient to cause death (b) If the execution of the sentence of death as provided in subsection (a) of this section is held unconstitutional, the sentence of death shall be executed by the administration of lethal gas . . . ").

[27] *Espy File, supra* n.25. The Idaho protocol provides alternatively for: (1) 5 g sodium pentothal, 120 mg pancuronium bromide, 240 mEq potassium chloride; (2) 5 g pentobarbital, 120 mg pancuronium bromide, 240 mEq potassium chloride; (3) 5 g sodium pentothal; or (4) 5 g pentobarbital. Idaho Department of Correction, General Administration, Operations Division, Standard Operating Procedure No. 135.02.01.001, Version 3.6, Appendix A (May 18, 1998, reviewed Jan. 6, 2012, scheduled for review Jan. 6, 2014) (*available at* www.idoc.idaho.gov/content/policy/708) (This policy appears to be outdated but the DOC has not posted a more recent version).

[28] *Espy File, supra* n.25. Kentucky previously promulgated a protocol using midazolam. 501 KAR 16:330, Lethal Injection Protocols. § 3 (*available at* www.lrc.ky.gov/kar/501/016/330.htm). However it dropped the use of midazolam after the botched use. Associated Press, *Kentucky Drops 2-Drug Executions, Reworking Method*, Nov. 14, 2014 (*available at* www.wlwt.com/news/kentucky-drops-2drug-executions-reworking-method/29716428)

[29] *Espy File, supra* n.25. The Montana legislature has provided for administration of lethal injection. Montana Code Annotated, Title 46, Ch. 19, § 103(3) ("administration of a continuous, intravenous injection of a lethal quantity of an ultra-fast-acting barbiturate in combination with a chemical paralytic agent"). The protocol was struck down in 2012. Laura Zuckerman, *Montana Judge Strikes Down State Execution Method*, WASHINGTON POST, Sept. 8, 2012 (*available at* www.washingtonpost.com/national/health-science/montana-judge-strikes-down-state-execution-

method/2012/09/08/4f34505a-f9e0-11e1-8398-0327ab83ab91_story.html).

[30] *Espy File*, *supra* n.25. The Nebraska protocol provides for the use of the *Baze* three drug protocol, with sodium thiopental, pancuronium bromide and potassium chloride. Nebraska Administrative Code, Title 69 – Department of Correctional Services, Chapter 11 – Execution Protocol, § 008. The supply of thiopental has expired. Joe Duggan, *Nebraska Lacks Drugs for Lethal Injections, Has No Way to Carry Out Executions*, OMAHA WORLD-HERALD, Feb. 4, 2014 (*available at* www.omaha.com/news/nebraska-lacks-drug-for-lethal-injections-has-no-way-to/article_4f2f70c0-d846-5582-86dc-3168b763b01a.html).

[31] *Espy File*, *supra* n.25. The South Dakota protocol provides various alternatives, none of which involve midazolam: (1) sodium thiopental, pancuronium bromide, potassium chloride; (2) pentobarbital, pancuronium bromide, potassium chloride; (3) sodium thiopental, pancuronium bromide; (4) pentobarbital, pancuronium bromide; (5) sodium thiopental; or (6) pentobarbital S. Dak. DOC Policy No. 1.3.D.3: Execution of an Inmate, Section (IV)(1)(A)(4) (effective Aug. 18, 2014) (*available at* doc.sd.gov/documents/about/policies/Execution%20of%20an%20Inmate.pdf).

[32] Letter from Charles L. Ryan, Director, Ariz. Dept. of Corrections, to Janice K. Brewer, Governor (Dec. 22, 2014) (*available at* corrections.az.gov/sites/default/files/documents/PDFs/letter_to_governor_brewer.pdf) (stating "it is my intent to retain the current one-drug protocols using either pentobarbital or sodium pentothal . and add two, three-drug protocols using either midazolam, vecuronium bromide, and potassium chloride or sodium pentothal, cecuronium bromide, and potassium chloride"). Arizona's most recent execution was botched. *See, e.g.*, Gary Grado, *Killer Was Given Two Doses of Lethal Injection Drugs in 'Botched' Execution*. Arizona Capitol Times, July 24, 2014 (*available at*

azcapitoltimes.com/news/2014/07/24/az-killer-joseph-wood-given-2-doses-of-lethal-injection-drug-in-botched-execution/).

[33] Tracy Connor, *Georgia Execution of Kelly Gissendaner Postponed for Drug Issue*, NBC NEWS, Mar. 2, 2015 (*available at* www.nbcnews.com/news/us-news/georgia-execution-kelly-gissendaner-postponed-drug-issue-n315651) (stating: "Georgia uses pentobarbital in a one-drug protocol for executions"). All executions in Georgia are currently postponed. Press Release, Georgia Department of Corrections, Court Ordered Executions Postponed – Kelly Renee Gissendaner and Brian Keith Terrell, Mar. 3, 2015 (*available at* www.dcor.state.ga.us/NewsRoom/PressReleases/PR_150303.html).

[34] *Zink v. Lombardi*, Case No. 2:12-CV-4209-NKL, W.D. Mo., Rec. Doc. 147-3 ("Missouri Department of Corrections, Preparation and Administration of Chemicals for Lethal Injection, Oct. 18, 2013").

[35] Execution Procedure Manual for Single Drug Protocol (Pentobarbital), Oct. 24, 2013 (*available at* www.ncdps.gov/div/AC/Protocol.pdf).

[36] Ohio stopped using midazolam after a series of botched executions. *See* Mark Berman, *Ohio Drops Controversial Lethal Injection Drug, Postpones Upcoming Execution*, WASHINGTON POST, Jan. 9. 2015 ("Ohio announced this week that it will no longer execute inmates with lethal injection drugs that were involved in two bungled executions last year, a change that will delay at least one execution and possibly others scheduled for this year."). The protocol is located at http://drc.ohio.gov/web/drc_policies/documents/01-COM-11.pdf.

[37] *West v. Schofield*, No. 14-00320, 2015 WL 1044098 (Tenn. Mar. 10, 2015) ("On September 27, 2013, the Tennessee Department of Correction adopted a new lethal injection protocol providing that inmates sentenced to death be

executed by the injection of a lethal dose of a single drug, pentobarbital")

[38] Texas Department of Criminal Justice, Death Row Facts, undated (*available at* www.tdcj.state.tx.us/death_row/dr_facts.html) (stating "Lethal Injection Consists Of: Single drug protocol of Pentobarbital").

[39] Utah Code, Title 77, Ch. 19, § 10: Judgment of death -- Location and procedures for execution (*available at* le.utah.gov/xcode/Title77/Chapter19/77-19-S10.html) (specifying "sodium thiopental; or other equally or more effective substance"). Bill is currently before governor that would reinstate firing squad if lethal injection drugs are not available. H.B. 11, Death Penalty Procedure Amendments, 2015 General Session (*available at* http://le.utah.gov/~2015/bills/static/HB0011.html).

[40] *See Hobbs v. McGehee*, No. 14-542) (oral argument held before Ark. S. Ct. on Feb. 19, 2015); *see also* Act 137 (2013) (*available at* www.arkleg.state.ar.us/acts/2013/Public/ACT139.pdf) (contemplating "intravenous lethal injection of a barbiturate in an amount sufficient to cause death" and that "[b]efore the intravenous lethal injection is administered, the condemned prisoner shall be intravenously administered a benzodiazepine.")

[41] Maura Dolan, *California Will No Longer Pursue Three-Drug Lethal Injections*, LOS ANGELES TIMES, July 10, 2013 (*available at* articles.latimes.com/2013/jul/10/local/la-me-ln-lethal-injection-20130710) (stating "California has dropped its legal efforts to win approval of a three-drug method of lethal injection and will instead propose single-drug executions" and that the DOC "did not know when a new, single-drug method would be unveiled or which drugs the state was considering" but "[t]he process could take years").

[42] In 2014, the Louisiana Legislature enacted a Department of Corrections led commission to "study and make recommendations relative to the different forms of execution and the method of execution to determine the best practices for administering the death penalty in the *most humane manner*." See La. HR 142 (2014). The Report on Study of Methods of Execution & Recommendations for Procedures was issued by the Louisiana Dept. of Public Safety and Corrections on February 18, 2015. The Report recommends utilizing a single drug protocol involving 5 gm of pentobarbital, and also recommended that the legislature consider nitrogen hypoxia as an alternate method. Della Hasselle, *Death Penalty Study Suggests Using Nitrogen to Carry Out Executions*, THE LENS. Mar. 4, 2014 (*available at* http://thelensnola.org/2015/03/04/death-penalty-study-suggests-using-nitrogen-to-carry-out-executions/) (discussing DPSC recommendations to legislature of adopting nitrogen hypoxia method).

[43] Prison where executions are performed has closed, unclear how many usable drugs remain. State of Nevada Legislative Auditor, Performance Audit: Fiscal Costs of the Death Penalty, Nov. 17, 2014, at 68 (*available at* www.leg.state.nv.us/Division/Audit/Full/BE2014/Costs%20of%20Death%20Penalty,%20LA14-25,%20Full.pdf) (stating that the Nevada State Prison, which housed the execution chamber, closed in May 2012, and that "NDOC management indicated it has a usable supply of drugs for an execution, if one were required, at a cost of about $587. However, we do not know how many executions NDOC can perform with the existing stock of drugs, when expiration dates will be exceeded, whether it can still obtain these drugs if more are needed, and what the cost might be to obtain drugs in the future."). Nevada previously used three-drug thiopental protocol. Martha Bellisle, *Nevada No Longer Able to Acquire Key Drug Used in Lethal Injections*, RENO GAZETTE-JOURNAL, Feb. 6, 2011 (*available at* archive.rgj.com/article/20110207/NEWS/105100001/Nevada-no-longer-able-acquire-key-drug-used-lethal-injections)

(discussing "sodium thiopental, one of three drugs used during the lethal injection process").

[44] *Roane et al. v. Holder et al.*. Case No. 1:05-cv-02237-RWR-DAR, Defendants' Status Report. Mar. 2, 2015, Rec. Doc. 348 (stating "[t]he Department of Justice and the Bureau [of Prisons] are currently engaged in a review of the [Lethal Injection Protocol used to effectuate death sentences]. This assessment is ongoing, and no final determinations have been made as to specific changes in the protocol.").

[45] Associated Press, *Delaware Lacks Lethal Injection Drugs Needed to Execute Death Row Inmates*, Mar. 5, 2014 (*available at* www.theguardian.com/world/2014/mar/05/delaware-lethal-injection-drugs-execute-17-condemned-prisoners) ("Under Delaware's current execution protocol, a condemned inmate is rendered unconscious by a sedative or anesthetic before receiving fatal and potentially painful doses of two paralytic drugs, pancuronium bromide and potassium chloride. Delaware used sodium thiopental as the initial drug before its sole U.S. manufacturer stopped making it in 2009. The state then began using pentobarbital."). State drug supply has reportedly expired. *Id.* ("Records show that the correction department obtained 50 vials of potassium chloride from Cardinal Health in February 2013, replacing 51 vials that expired that same month. The current supply of potassium chloride, enough for four executions, expires in October. Meanwhile, supplies of the other two drugs, pancuronium bromide and pentobarbital, expired in July 2012 and September 2013, respectively.")

[46] Announced Brevital (methohexital sodium) in a 3 drug protocol, but no formal protocol change. Associated Press. *Indiana Use of New Execution Drug Draws Opposition*, May 31, 2014 (*available at* www.cbsnews.com/news/indiana-use-of-new-execution-drug-draws-opposition/) (stating "Indiana State Prison Superintendent Bill Wilson selected Brevital as a replacement for sodium thiopental" "as part of its three-drug lethal injection series").

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[47] Mississippi Department of Corrections, Media Kit, Execution by Lethal Injection: Contents of Syringes for Lethal Injection, June 12, 2012 (*available at* www.mdoc.state.ms.us/Media%20Kit/Media%20Kit%20BRAWNER.pdf). Previously used Sodium Thiopental as first of three drugs. Chris Elkins, *Mississippi Affected by Shortage of Execution Drug*, Northeast Mississippi Daily Journal, Jan. 26, 2011 (*available at* djournal.com/news/mississippi-affected-by-shortage-of-execution-drug/) (stating that the state was running low on sodium thiopental and was looking for an alternative drug).

[48] State does not currently have usable drugs. Meg Kinnard, *South Carolina Has Run Out of Lethal Injection Drug*, ASSOCIATED PRESS, Mar. 9, 2015, (*available at* www.thestate.com/2015/03/09/4035143/ south-carolina-has-run-out-of.html) ("Corrections Director Bryan Stirling recently told The Associated Press the state's supply of pentobarbital expired in September 2013 and was discarded, as its effectiveness had worn off. The state still has the other two drugs it uses in its lethal injection — pancuronium bromide and potassium chloride. When South Carolina looked to replenish its pentobarbital supplies, officials found no willing vendors.").

[49] Press Release, Virginia Department of Corrections Adds Alternative Lethal Injection Chemical, Feb. 20, 2014 (*available at* vadoc.virginia.gov/news/press-releases/14feb20_finalLIdrugs release.shtm) (stating that "Midazolam will be added to [Virginia's] list of lethal injection drugs approved for use in conducting state executions" and that it "will serve as an alternative first drug in Virginia's three-drug protocol." *See also* Press Release, Virginia Department of Corrections Adds Alternative Lethal Injection Chemical, May 9, 2011 (*available at* vadoc.virginia.gov/news/press-releases/11may09_pentobarbital.shtm) (stating that "due to the current shortage of Sodium Thiopental, the drug Pentobarbital will be added to [Virginia's] list of lethal injection drugs").

[50] Associated Press, *Alabama's New Lethal Injection Drugs Challenged*, Oct. 4, 2014 (*available at* www.al.com/news/index.ssf/2014/10/alabamas_new_lethal_injection.html) ("The new drug protocol calls for the sequential injections of 500 milligrams of midazolam hydrochloride, a sedative; 600 milligrams of rocuronium bromide, a neuromuscular blocking agent that stops breathing; and 240 'milliequivalents' of potassium chloride to stop the heart.").

[51] Oklahoma Department of Corrections, Policy No. OSP-040301-01: Procedures for the Execution of Offenders Sentenced to Death, Mar. 21, 2014 (*available at* localtvkfor.files.wordpress.com/2014/03/newlethalinjectionprotocol.pdf).

[52] Florida Dept. of Corrections, *Execution by Lethal Injection Procedures*, § (12)(c), Sept. 9, 2013 (*available at* deathpenaltyinfo.org/documents/FLExecProtocol.pdf).

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Petitioners,

v.

KEVIN J. GROSS, *ET AL.*,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Tenth Circuit

BRIEF OF *AMICUS CURIAE* THE RUTHERFORD INSTITUTE IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICUS* 1

SUMMARY OF THE ARGUMENT 2

ARGUMENT 2

I. BASIC INFORMATION ABOUT A STATE'S LETHAL INJECTION DRUG SUPPLY IS OFTEN SHROUDED IN SECRECY 2

II. SUCH SECRECY IS PARTICULARLY TROUBLING IN LIGHT OF THE RISKS OF COMPOUNDED DRUGS 7

CONCLUSION 12

TABLE OF AUTHORITIES

Cases

Baze v. Rees,
553 U.S. 35 (2008) 2, 3, 11

Ladd v. Livingston,
777 F.3d 286 (5th Cir.), *cert. denied*, 135 S. Ct. 1197 (2015) 6, 11

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732 F.3d 465 (5th Cir. 2013) 11

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Ark. Code § 5-4-617 (2013) 4

Fla. Stat. Ann. § 945.10(1)(g) (2014) 4

2000 Fla. Sess. Law.
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South Dakota Carries Out Execution Using Contaminated Compounded Drug, Reprieve, Oct. 17, 2012, http://www.reprieve.org.uk/press/2012_10_17_compound_pharmacy_death_penalty 8

INTEREST OF *AMICUS*[1]

The Rutherford Institute is an international nonprofit civil liberties organization headquartered in Charlottesville, Virginia. Founded in 1982 by its President, John W. Whitehead, the Institute provides *pro bono* legal representation to individuals whose civil liberties are threatened and educates the public about constitutional and human rights issues.

Among the purposes of The Rutherford Institute is to foster respect for the uniqueness and paramount worth of human life and to stridently defend fundamental notions of fairness and equality under the law. These values find their roots in an informed citizenry that has the knowledge to hold its government accountable.

The Rutherford Institute is interested in this case because it believes that if the death penalty is to remain a form of punishment in this country, then the methods of execution employed—including the properties of the lethal injection drugs—must be subject to scrutiny by inmates, courts, and citizens. Such review is crucial to safeguarding the

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[1] All parties to this matter have granted blanket consent for amicus curiae briefs in support of either or neither party. Petitioners filed such consent on March 4, 2015, and Respondents filed such consent on March 6, 2015. The requirements of Rule 37.2(a) of the rules of this court are satisfied by these filings. No counsel for a party authored this brief in whole or in part, and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of this brief. No one other than *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

constitutional right against cruel and unusual punishment. Moreover, it will ensure informed discourse regarding the death penalty that is vital to constitutional jurisprudence and the growth and progress of the nation.

SUMMARY OF THE ARGUMENT

Amicus supports Petitioners' claim that Oklahoma's use of midazolam as the first drug in its three-drug lethal injection protocol violates the Eighth Amendment standard set forth in *Baze v. Rees*, 553 U.S. 35 (2008). Because the drug does not anesthetize a person completely, its use poses an unconstitutional risk that the inmate will remain conscious as the next two drugs in the sequence, pancuronium bromide and potassium chloride—which cause excruciating pain—are administered.

Rather than repeat Petitioners' arguments, this brief calls attention to the tendency of some states to keep the sources of their lethal injection drugs secret. *Amicus* believes that understanding current state practices may inform any guidance the Court might provide in resolving the question currently before it.

ARGUMENT

I. BASIC INFORMATION ABOUT A STATE'S LETHAL INJECTION DRUG SUPPLY IS OFTEN SHROUDED IN SECRECY

States' lethal injection practices have never

been a paragon of transparency.[2] In the years since *Baze v. Rees*, 553 U.S. 35 (2008), however, the secrecy has worsened. Since then, a growing number of states have adopted secrecy laws shielding the source of their lethal injection drugs from any form of public review. Even states that have not adopted such laws have resisted disclosure of such information on other grounds.

The impetus for these laws is no secret. Shortages of lethal injection drugs since 2011 have forced states to turn to less conventional means to obtain their drugs—most commonly, compounding pharmacies, which are subject to less rigorous regulation. States claim that their secrecy laws preserve the anonymity of these pharmacies, which otherwise face harassment. But even if that is true, the secrecy has extended beyond the identities of the compounding pharmacies to shield even their safety records and laboratory test results. In short, the secrecy extends to the very information necessary to determine whether a drug will work in a constitutional manner.

Of the thirty-four states that use lethal injection, at least twelve have adopted laws or policies resisting disclosure of their lethal injection drug suppliers:

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[2] *See, e.g.*, Deborah W. Denno, *Lethal Injection Chaos Post-Baze*, 102 Geo. L.J. 1331, 1379-80 (2014) (noting that, at the time of her 2005 study of lethal injection protocols, "one-half of the states that applied lethal injection did not allow any evaluation of their protocols, either because the information is confidential or nonexistent").

Since 2011, six states have enacted supplier-secrecy statutes expressly preventing the public from learning where the states obtained their lethal injection drugs.[3] In 2011, Oklahoma became the first state to enact such a law in response to the drug shortage, providing complete anonymity to drug suppliers and shielding them from all civil or criminal discovery.[4] Georgia, Arkansas, South Dakota, and Tennessee followed suit in 2013.[5] Georgia conferred "confidential state secret" status on the identities of drug suppliers, while Arkansas exempted such information from the state's Freedom of Information Act. Most recently, in December 2014, Ohio passed a supplier secrecy law protecting suppliers of lethal injection drugs from having their names divulged for 20 years.[6]

Two states, Arizona and Missouri, have achieved the same result by reinterpreting existing secrecy statutes shielding "members" of the execution team to encompass drug suppliers as well.[7]

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[3] A seventh state, Florida, has long exempted information about persons who compound drugs from its public records inspection statute, pre-dating the current drug shortage. *See* Fla. Stat. Ann. § 945.10(1)(g) (2014); 2000 Fla. Sess. Law. Serv. Ch. 2000-1 (S.B. 4A).

[4] Okla. Stat. § 22-17-1015(B) (2011).

[5] Ark. Code § 5-4-617 (2013); Ga. Code. Ann. § 42-5-36(d)(1)-(2)(2013); S.D. Codified Laws § 23A-27A-31.2 (2013); Tenn. Code Ann. § 10-7-504(16)(h)(1) (2014).

[6] Ohio Rev. Code § 2949.221 (2015); Alan Johnson, *New Law Will Keep Lethal Injection Drug Supplier Secret*, Columbus Dispatch, Dec. 20, 2014, http://www.dispatch.com/content/stories/local/2014/12/19/new-law-will-keep-lethal-injection-drug-supplier-secret.html.

[7] *See* Press Release, Arizona Attorney General's

Lastly, three other states—Texas, Idaho, and Pennsylvania—do not have secrecy laws, but have nevertheless attempted to withhold drug supplier information as a policy matter.[8]

States have construed these laws broadly to shield all information that *might* permit a compounding pharmacy to be identified.

Thus, relying on these secrecy laws, some states have refused to provide any evidence of laboratory testing or other assurances of quality—to prisoners, the media, and even courts. In the days leading up to Michael Anthony Taylor's execution in Missouri, for example, Missouri refused to admit that its drugs were compounded or to permit them to be tested. *See Taylor v. Lombardi*, No. 14-1388, slip

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Office, *State of Arizona Announces Change to Lethal Injection Protocol* (Mar 26, 2011), *available at* https://www.azag.gov/press-release/state-arizona-announces-change-lethal-injection-protocol *and* Ariz. Rev. Stat. Ann. § 13-757(C)(2009) (shielding the "identity of executioners and other persons who participate or perform ancillary functions in an execution"); Press Release, State of Missouri Dep't of Corrections, *Missouri Department of Corrections Adopts New One-Drug Execution Protocol* (Oct. 22, 2013), *available at* http://doc.mo.gov/PressReleases/2013/20131022.pdf (adding a compounding pharmacy to its execution team) *and* Mo. Rev. Stat. 546.720(2) (2007).

[8] *See* Ed Pilkington, *Pennsylvania Challenged Over Execution Drugs Secrecy in Federal Court*, The Guardian, Sept. 17, 2014, http://www.theguardian.com/world/2014/sep/11/aclu-challenges-pennsylvania-lethal-injection-secrecy; Terri Langford, *AG: Prisons Can Keep Info About Execution Drugs Secret*, Texas Trib., May 29, 2014, https://www.texastribune.org/2014/05/29/ag-says-prisons-can-keep-execution-drugs-secret; *Idaho Refuses to Disclose Lethal Injection Drug Source*, KTVB.com, May, 1 2014, http://www.ktvb.com/story/news/local/2014/07/03/12163337.

op. at 3 (8th Cir. Feb. 25, 2014) (Bye, J., dissenting) ("Although there were concerns with previous laboratory testing, at least some laboratory testing was conducted. Now, Missouri has provided no indication any testing of the new product has occurred."), *cert. denied*, 134 S. Ct. 1375 (U.S. Feb. 25, 2014); *Landrigan v. Brewer*, 625 F.3d 1132, 1135 (9th Cir.) (noting that "[t]he State [of Arizona] made no showing about the efficacy of the drug it obtained," and that it did not even submit an affidavit stating that the drug was obtained through reputable sources or there was no reason to question that it would function as intended), *vacated*, 131 S. Ct. 445 (2010).

Still others have represented that the drug they intend to use is sufficiently potent, while steadfastly refusing to turn over the underlying basis for their assurances. *See, e.g.*, *Ladd v. Livingston*, 777 F.3d 286, 289 (5th Cir.) (State of Texas maintained that its pentobarbital was unexpired, obtained from a licensed compounding pharmacy and found to be free of contaminants), *cert. denied*, 135 S. Ct. 1197 (2015); *Sells v. Livingston*, 750 F.3d 478, 481 (5th Cir. 2014) (State of Texas disclosed that "the batch from which the dose will be taken has been tested by an independent laboratory. That test revealed that it has a potency of 108%, and is free of contaminants."). Although better than not offering assurances as to the quality of the drug at all, such statements amount to little more than a "just trust us."[9]

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[9] On February 9, 2015, in response to the growing number of lethal injection secrecy laws, the American Bar Association passed Resolution 108B, calling for "open and

II. SUCH SECRECY IS PARTICULARLY TROUBLING IN LIGHT OF THE RISKS OF COMPOUNDED DRUGS

Whether or not a drug will work as intended can make the difference between a quiet death and an excruciating one that violates the Eighth Amendment.[10] If the compounding process is performed correctly, it can result in a safe, effective drug that will function as an equivalent to the manufactured version of the same drug. But the risk that a compounded drug may be contaminated is all too real. In October 2012, South Dakota executed Eric Robert using a dose of compounded pentobarbital. Robert began snoring and then remained open-eyed during the twenty minutes it took for him to die.[11] The pentobarbital was later

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transparent" disclosure of execution protocols. *See* American Bar Association, Report to House of Delegates, Resolution 108b (Feb. 9, 2015), *available at* http://www.americanbar.org/content/dam/aba/administrative/house_of_delegates/resolutions/2015_hod_midyear_meeting_108b.docx.

[10] An execution dose of pentobarbital, for instance, is meant to quickly render an inmate unconscious and without awareness until death occurs. By contrast, the effect of *contaminated* pentobarbital has been described as sandpaper on the inside of one's veins. Molly Redden, *New Lethal Injections Could Cause Extreme Pain, Make Deaths "Drag On" for Hours*, Mother Jones, Nov. 7, 2013, http://www.motherjones.com/politics/2013/11/ohio-lethal injection-cocktail-execution-drugs.

[11] Dave Kolpack & Kristi Eaton, *Eric Robert Execution: South Dakota Executes Inmate Who Killed Prison Guard*, Huffington Post, Oct. 16, 2012, http://www.huffingtonpost.com/2012/10/16/eric-robertexecution_n_1969640.html.

found to be contaminated with fungus.[12] In January 2014, during Oklahoma's execution of Michael Lee Wilson with compounded pentobarbital, he cried out, "I feel my whole body burning," a sensation consistent with that caused by contaminated pentobarbital.[13] Most recently, in early March 2015, a Georgia woman's execution was called off when prison officials noticed the compounded pentobarbital planned for her lethal injection appeared cloudy rather than clear.[14]

These incidents highlight the risks of a system that allows states to use compounded drugs with little to no checks or balances.[15] Compounded drugs

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12 *South Dakota Carries Out Execution Using Contaminated Compounded Drug*, Reprieve, Oct. 17, 2012, http://www.reprieve.org.uk/press/2012_10_17_compound_pharmacy_death_penalty.

13 Rick Lyman, *Ohio Execution Using Untested Drug Cocktail Renews the Debate Over Lethal Injections*, N.Y. Times, Jan. 16, 2014, http://www.nytimes.com/2014/01/17/us/ohio-execution-using-untested-drug-cocktail-renews-the-debate-over-lethal-injections.html.

14 Alan Blinder, *Georgia Postpones 2 Executions, Citing 'Cloudy' Drug*, N.Y. Times, Mar. 3, 2015, http://www.nytimes. com/2015/03/04/us/execution-of-georgia-woman-is-postponed-indefinitely.html.

15 Since late 2012, at least five states have carried out executions using compounded drugs: Georgia, Missouri, Oklahoma, South Dakota, and Texas. *See* Nathaniel N.W. Crider, *What You Don't Know Will Kill You: A First Amendment Challenge to Lethal Injection Secrecy*, 48 COLUM. J. L. & SOC. PROBS. 1, 3-4 n.12,13 (2014). At least another four have announced their intentions to rely on compounded drugs, but have not yet carried out executions using compounded drugs: Louisiana, Mississippi, Ohio, and Pennsylvania. *Id.*

are not approved by the Food and Drug Administration ("FDA") and need not meet FDA standards.[16] Inspections by the Missouri Board of Pharmacy have found that about one out of every five drugs made by compounding pharmacies in that state failed to meet standards.[17] Between 2012 and

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These nine states collectively carried out 54 of the 74 executions (or 73% of the executions) between 2013 and 2014. *See Execution List 2013*, Death Penalty Information Center, http://www.deathpenaltyinfo.org/execution-list-2013 (last visited Mar. 15, 2015) *and Execution List 2014*, Death Penalty Information Center, http://www.deathpenaltyinfo.org/execution-list-2014 (last visited Mar. 15, 2015).

[16] For instance, a 2003 FDA report revealed that of 29 samples of products collected from 12 different compounding pharmacies, ten (or 34%) failed one or more of the standard quality tests performed. *See* Report: Limited FDA Survey of Compounded Drug Products, FDA, http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/PharmacyCompounding/ucm155725.htm (last visited Mar. 15, 2015). By contrast, the failure rate for commercially-produced samples was less than 2%. *Id.*

Similarly, a 2006 FDA report sampled 198 products from compounding pharmacies throughout the country, broken down into 125 active pharmaceutical ingredients and 73 finished compounded drug products. *2006 Limited FDA Survey of Compounded Drug Products*, FDA, http://www.fda.gov/ Drugs/GuidanceComplianceRegulatory Information/PharmacyCompounding/ucm204237.htm (last visited Mar. 15, 2015). All 198 drugs were analyzed for identification of active ingredient, potency, and for drugs in capsule form, content uniformity. *Id.* Although all active ingredients passed analysis, a third of the compounded drugs failed. *Id.*

[17] Chris McDaniel, *Federal Judges Rule Execution Drug Supplier Can Be Secret, But Documents Point To Likely Identity*, St. Louis Public Radio, Jan. 25, 2014, http://news.stlpublicradio.org/post/federal-judges-rule-

2014, nearly a third of Ohio's 61 state-licensed compounding pharmacies were cited for various violations, including two resulting in license revocations.[18] The quality of compounded drugs from the same pharmacy can also vary from batch to batch, as compounding pharmacies make customized drugs on an as-needed basis.[19]

There is, moreover, reason to question whether states do sufficient due diligence on a pharmacy before utilizing it. In many cases a state is driven to a particular pharmacy because it is the only one willing to provide a compounded drug.[20] In March 2013, for example, the Colorado Department of Corrections mass-mailed nearly a hundred local compounding pharmacies seeking to "acquire sodium thiopental or other equally or more effective substance to cause death."[21] Meanwhile, an

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execution-drug-supplier-can-be-secret-documents-point-likely-identity.

[18] Alan Johnson, *Secrecy For Lethal Injections Nears Ohio Legislature's OK*, Columbus Dispatch, Dec. 17, 2014, http://www.dispatch.com/content/stories/local/2014/12/17/secrecy-for-lethal-injections-nears-legislatures-ok.html.

[19] *See* Denno, *supra* note 2, at 1336-1375.

[20] *See, e.g.*, Meg Kinnard, *South Carolina Has Run Out Of Lethal Injection Drug*, Associated Press, Mar. 9, 2015 http://www.thestate.com/2015/03/09/4035143/south-carolina-has-run-out-of.html; Mark Berman, *Texas Is About To Run Out Of Lethal Injection Drugs*, Wash. Post, Mar. 10, 2015, http://www.washingtonpost.com/news/post-nation/wp/ 2015/03/10/texas-is-about-to-run-out-of-lethal-injection-drugs.

[21] Tim Hoover, *Colorado Asks Pharmacists For Help In Securing Lethal Injection Drug*, Denver Post, Mar. 12, 2013, http://www.denverpost.com/ci_22775748/colorado-asks-pharmacists-help-securing-lethal-injection-drug.

investigative piece by St. Louis Public Radio in late 2013 revealed that Missouri's drug supplier was located in Oklahoma—and thus not even overseen by the Missouri Board of Pharmacy.[22]

Without transparency, it becomes impossible to test that state's protocol against the Eighth Amendment standard set forth in *Baze*. 553 U.S. at 49-50.[23] For instance, the Fifth Circuit requires an inmate to "offer some proof that the state's own process—that its choice of pharmacy, that its lab results, that the training of its executioners, and so forth, are suspect" to make out a viable Eighth Amendment claim. *Ladd*, 777 F.3d at 289 (*quoting Whitaker v. Livingston*, 732 F.3d 465, 468 (5th Cir. 2013)). But a State need simply claim reliance on its secrecy statute to avoid disclosing any of the above pieces of information—allowing it to avoid Eighth Amendment scrutiny altogether. This should not and cannot be the rule.

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[22] Chris McDaniel & Veronica LaCapra, *Investigation: Missouri's Execution Drug Source Raises Legal, Ethical Questions*, St. Louis Public Radio, Dec. 31, 2013, http://news.stlpublicradio.org/post/investigation-missouris-execution-drug-source-raises-legal-ethical-questions. In fact, the purchase of drugs from a compounding pharmacy not licensed in Missouri violates Missouri state law. *Id.*

[23] *See generally* Eric Berger, *Lethal Injection Secrecy and Eighth Amendment Due Process*, 55 B.C.L. REV. 1367 (2014); *see also* Crider, *supra* note 15.

CONCLUSION

To the extent that the Court considers this issue at all, *Amicus* respectfully submits that any guidance this Court provides should emphasize the importance of information and transparency in lethal injection practices.

Respectfully submitted,

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IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, *et al.*,

Petitioners,

v.

KEVIN J. GROSS,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE TENTH CIRCUIT

BRIEF OF SIXTEEN PROFESSORS OF PHARMACOLOGY AS *AMICI CURIAE* IN SUPPORT OF NEITHER PARTY

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TABLE OF CONTENTS

Page

Statement of Interest of *Amici Curiae* 1

Summary of Argument 8

Argument 9

I. Background 9

II. Midazolam Is a Fast-Acting Benzodiazepine that Produces Reliable Hypnosis, Amnesia, and Anti-anxiety Effects 10

III. Midazolam Is Incapable of Rendering an Individual Unconscious 11

A. Background on Neurotransmission and Neuronal Inhibition 11

B. Midazolam Promotes CNS Depression Only in the Presence of GABA by Increasing the Frequency of Ion Channel Opening 13

C. Barbiturates Depress the CNS by Increasing the Duration of Ion Channel Opening Even in the Absence of GABA 16

D. Because Midazolam Requires Co-Binding of GABA and the Amount of GABA is Limited, Midazolam Cannot Overcome Sub-Anesthetic Levels To Provide General Anesthesia 17

Conclusion 20

TABLE OF CITED AUTHORITIES

Page

CASES

Warner v. Gross,
776 F.3d 721 (10th Cir. 2015) 8, 9, 11, 18

OTHER AUTHORITIES

Brett A. Cromer *et al.*, *Anxiety over $GABA_A$ Receptor Structure Relieved by AChBP*, 27 Trends in Biochemical Sciences 280 (2002).....15

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Werner Sieghart, *Allosteric Modulation of $GABA_A$ Receptors via Multiple Drug-Binding Sites*, 72 Advances in Pharmacology 53 (2015) 14

STATEMENT OF INTEREST OF *AMICI CURIAE*

Amici curiae, each of whom is listed below, are professors of pharmacology at universities in the United States.[1] *Amici curiae* respectfully submit this brief to provide a pharmacological perspective on the physiologic effect of midazolam hydrochloride ("midazolam"). Midazolam is a sedative in the benzodiazepine class of drugs that the State of Oklahoma decided to use in early 2014 as a substitute for sodium thiopental ("thiopental") and pentobarbital as the first drug in the State's three-drug lethal injection protocol. *Amici curiae* have no interest in any party to this litigation, nor any stake in the outcome of this case.[2]

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[1] No counsel for a party authored this brief in whole or in part, and no such counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than the *amici*, or their counsel, made a monetary contribution intended to fund its preparation or submission. The parties have filed blanket waivers with the Court consenting to the submission of all *amicus* briefs.

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Letters from the parties consenting to the filing of *amicus curiae* briefs, in support of either party or neither party, have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

The first drug in the State of Oklahoma's three-drug lethal injection protocol is intended to ensure an inmate is in a "deep, comalike unconsciousness" prior to the injection of a paralytic agent to stop respiration, and a drug that induces cardiac arrest. *Warner v. Gross*, 776 F.3d 721, 724-25 (10th Cir. 2015), *cert. granted*, 135 S. Ct. 1173 (2015). Since early 2014, the State of Oklahoma has used midazolam as the first drug in this sequence. From a pharmacological perspective, however, midazolam is not appropriate for its intended purpose.

There is overwhelming scientific consensus, including among pharmacologists, that midazolam is incapable of inducing a "deep, comalike unconsciousness," *id.* The biochemical interaction by which midazolam produces its pharmacological effect on the human body (i.e., its mechanism of action) requires co-binding of a neurotransmitter, known as γ-aminobutyric acid ("GABA"), and midazolam to depress the activity of the central nervous system ("CNS"). But the depth of that depression is limited, and even an excessive dose of midazolam will not result in unconsciousness.

ARGUMENT

I. Background

Before the Director of Oklahoma's Department of Corrections selected midazolam for use as the first drug in the three-drug lethal injection protocol in early 2014, the State of Oklahoma used drugs in the barbiturate class known to "induce[] a deep, comalike unconsciousness when given in the amounts used for lethal injection." *Id.* at 724-25 (citing *Baze v. Rees*, 553 U.S. 35, 44 (2008)). Until approximately 2010, the State of Oklahoma used thiopental, a member of the barbiturate drug class, as the first drug. *Id.* at 725. Later, it substituted an alternative drug in the same barbiturate class, pentobarbital, as the first drug in the protocol. *Id.* But in 2014, the State of Oklahoma elected to use midazolam in its place. *Id.*

Midazolam is not an appropriate substitute for thiopental or pentobarbital as the first drug in the State of Oklahoma's three-drug lethal injection protocol. Increasing doses of barbiturates, including thiopental and pentobarbital, will induce sedation, then sleepiness, then anesthesia, then coma, and finally death. Midazolam, however, is not a member of the barbiturate drug class. It is a benzodiazepine, a separate class of drugs that does not exert its pharmacological effect in the same manner as barbiturates. This pharmacological distinction explains why midazolam cannot induce unconsciousness at any dose, and why it is not an appropriate substitute for either thiopental or pentobarbital as the first drug in a three-drug lethal injection protocol.

II. Midazolam Is a Fast-Acting Benzodiazepine that Produces Reliable Hypnosis, Amnesia, and Anti-anxiety Effects

Midazolam was first synthesized in 1976 and belongs to a class of drugs called benzodiazepines. J.G. Reves *et al.*, *Midazolam: Pharmacology and Uses*, 62 Anesthesiology 310, 310 (1985). Benzodiazepines are CNS depressants that reliably provide sedative, hypnotic[3], muscle relaxant, anxiety inhibitory, and anticonvulsant effects. Dennis S. Charney *et al.*, *Hypnotics and Sedatives, in Goodman & Gilman's The Pharmacological Basis of Therapeutics* 401, 410-11 (James F. Shanahan *et al.* eds., 11th ed. 2006); Reves at 311-12. In addition to midazolam, the benzodiazepine family also includes the active pharmaceutical ingredients in XANAX® (alprazolam), KLONOPIN® (clonazepam), VALIUM® (diazepam), and ATIVAN® (lorazepam), among others. Charney at 410-11.

Structurally speaking, midazolam differs from other benzodiazepines in that it has a fused imidazole ring, which confers unique physiochemical properties, including basicity (as opposed to acidity), stability in aqueous solution, and rapid metabolism in the body. Reves at 310. At physiologic pH (i.e., pH of the blood), midazolam becomes highly lipophilic (i.e., able to dissolve in fats), giving rise to

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[3] Hypnotic drugs "produce[] drowsiness and facilitate[] the onset and maintenance of a state of sleep that resembles natural sleep in its electroencephalographic characteristics and from which the recipient can be aroused easily." Charney at 401.

various clinical consequences, including rapid entry of midazolam into brain tissue and very rapid onset of activity following intravenous administration. *Id.* at 315. Although it is fast acting, midazolam also has a short duration of activity due to its very high metabolic clearance and rapid rate of elimination from the body. *Id.* Termination of the clinical effect following a single dose of midazolam is also rapid. *Id.*

These properties make midazolam an attractive choice as a pre-medication given prior to the induction of anesthesia. *Id.* at 317-18. But while midazolam produces sleep and amnesia, with a short duration of activity, it cannot be used to render a person unconscious or to maintain general anesthesia. *Id.*

III. Midazolam Is Incapable of Rendering an Individual Unconscious

Midazolam's mechanism of action differs from barbiturates. This critical difference demonstrates why midazolam cannot induce unconsciousness, and why it is an improper substitute for thiopental or pentobarbital as the first drug in the State of Oklahoma's three-drug lethal injection protocol.

A. Background on Neurotransmission and Neuronal Inhibition

To understand how midazolam works on the body—and ultimately to convey why midazolam is incapable of "render[ing] an inmate unconscious prior to the injection of the second and third drugs," *Warner*, 776 F.3d at 725—requires some background

on neurotransmission, the process by which neurons (i.e., nerve cells) receive, conduct, and transmit signals.

Neurotransmission is at the heart of every action in our daily lives, taking a stimulus, converting it into a nerve impulse, and resulting in some action or inaction. When we touch a hot burner on a stove, we immediately pull our hand away. In the home, this is a clumsy kitchen mishap. But in the classroom, this is a classic lesson in neurotransmission. At the biochemical level, touching the hot burner stimulates heat and pain receptors on the hand, which send nerve impulses to the spinal cord. Those nerve impulses are then transferred to neurons that are ultimately connected to the muscles in the arm and hand that are stimulated to contract to pull the hand away. This cascade of events is the result of a series of electrochemical reactions mediated by neurotransmitters. Neurotransmitters are chemicals that bind to receptors, causing ion channels to open or close, thus exciting or inhibiting individual neurons.

GABA is the major inhibitory neurotransmitter in the human body. *E.g.*, Bruce Alberts *et al.*, *Membrane Transport, in Essential Cell Biology* 371, 400-01 (1998); Charney at 405. When inhibitory neurons of the brain release GABA onto other brain neurons, GABA binds to GABA-specific receptors. Alberts at 400-01. This binding causes chloride ion channels to open on the recipient neurons. *Id.* The influx of chloride ions through the channel causes those neurons to become more

quiescent, to decrease in electrical activity, and to decrease the likelihood of neuronal firing. *Id.* at 401. The result is neuronal inhibition and ultimately CNS depression. *Id.*

By way of example, seizures result from a failure of inhibitory neurotransmission, and there is substantial evidence linking epilepsy with dysfunction of GABA-specific neuronal inhibition. L. John Greenfield Jr., *Molecular Mechanisms of Antiseizure Drug Activity at $GABA_A$ Receptors*, 22 Seizure 589, 589 (2013). Drugs that block or dampen GABA's effect on binding to the GABA receptor are called "antagonists." *Id.* By preventing or decreasing the likelihood of chloride ion influx through the ion channel, these antagonists can induce seizures. *Id.* Conversely, drugs that activate the GABA receptor are called "agonists," and by increasing the frequency of ion channel opening, or increasing the opening time of the ion channel to longer durations, agonists work to sustain neuronal inhibition and control seizures. *Id.* at 590-92. Even outside of the context of seizures, pharmaceutically promoting neuronal inhibition requires agonists that enhance the chloride ion channel permeability of GABA receptors. *E.g.*, Alberts at 401.

B. Midazolam Promotes CNS Depression Only in the Presence of GABA by Increasing the Frequency of Ion Channel Opening

Once in the body, midazolam, like all benzodiazepines, acts by promoting the binding of the neurotransmitter GABA to the $GABA_A$ receptor. Charney at 402; Reves at 311-12; Greenfield at 591.

$GABA_A$ receptors, a sub-type of GABA receptors, are ion channels with multiple binding sites that can be opened by GABA, but that also can be modulated by drugs, including benzodiazepines. Werner Sieghart, *Allosteric Modulation of $GABA_A$ Receptors via Multiple Drug-Binding Sites*, 72 Advances in Pharmacology 53, 54-55 (2015).

When midazolam alone binds to the $GABA_A$ receptor, there is no inhibitory neuronal consequence. Erwin Sigel & Michael E. Steinmann, *Structure, Function, and Modulation of $GABA_A$ Receptors*, 287 Journal of Biological Chemistry 40224, 40227 (2012); Charlotte D'Hulst *et al.*, *The Complexity of the $GABA_A$ Receptor Shapes Unique Pharmacological Profiles*, 14 Drug Discovery Today 866, 872 (2009); Charney at 405. In other words, the binding of midazolam alone to the $GABA_A$ receptor does not open the ion channel to allow for chloride ion influx into the neuron. Rather, midazolam requires the additional co-binding of GABA to the $GABA_A$ receptor to exert an inhibitory effect. D'Hulst at 872; Charney at 405-06; Werner Sieghart *et al.*, *A Novel $GABA_A$ Receptor Pharmacology: Drugs Interfacing with the $\alpha^+\beta^-$ Interface*, 166 British Journal of Pharmacology 476, 476-77 (2012). This requires coordination, as neuronal inhibition by midazolam therefore requires GABA to be released by inhibitory neurons and available to bind to the $GABA_A$ receptor at the same time that the drug is available to bind. D'Hulst at 872; Charney at 405-06; Sieghart (2012) at 477.

Midazolam and GABA bind to the $GABA_A$ receptor at distinct sites. Brett A. Cromer *et al.*,

Anxiety over $GABA_A$ Receptor Structure Relieved by AChBP, 27 Trends in Biochemical Sciences 280, 280 (2002); M. Ernst *et al.*, *Comparative Modeling of $GABA_A$ Receptors: Limits, Insights, Future Developments*, 119 Neuroscience 933, 938-39 (2003). When midazolam binds to the benzodiazepine site on a $GABA_A$ receptor, this leads to a conformational change of the receptor itself. Sigel & Steinmann at 40227. The conformational change increases the affinity of the GABA neurotransmitter to its own $GABA_A$ receptor binding site. *Id.*; Charney at 406. The increased affinity of GABA for the $GABA_A$ receptor binding site means that in the presence of bound midazolam, even sub-maximal amounts of GABA will open the $GABA_A$ ion channel. Sigel & Steinmann at 40227; Charney at 406.

The result of co-application of midazolam and GABA to the $GABA_A$ receptor is an increase in the frequency of chloride ion channel opening. Sigel & Steinmann at 40228; Robert E. Study & Jeffrey L. Barker, *Diazepam and (–)-Pentobarbital: Fluctuation Analysis Reveals Different Mechanisms for Potentiation of γ-aminobutyric Acid Responses in Cultured Central Neurons*, 78 Proceedings of the National Academy of Sciences USA 7180, 7183 (1981); Carl J. Rogers *et al.*, *Benzodiazepine and β-carboline Regulation of Single $GABA_A$ Receptor Channels of Mouse Spinal Neurones in Culture*, 475 Journal of Physiology 69, 69, 72-73, 77, 79 (1994); Charney at 406. The resultant influx of chloride ions into the neuron suppresses neuronal firing, and ultimately produces the hallmark sedative and hypnotic effects of the drug. *E.g.*, Alberts at 400-01; D'Hulst at 866.

By way of analogy, the $GABA_A$ receptor can be thought of as a keyed gate through which chloride ions can enter a neuron. GABA and midazolam are keys to that gate. The GABA key alone opens the gate, allowing for chloride ion influx. The midazolam key alone does not open the gate, but simultaneous use of the GABA and midazolam keys results in increased frequency of gate opening, as compared to the frequency of gate opening using the GABA key alone.

C. Barbiturates Depress the CNS by Increasing the Duration of Ion Channel Opening Even in the Absence of GABA

Barbiturates, including thiopental and pentobarbital, also act on the $GABA_A$ receptor. *E.g.*, Richard W. Olsen & Adele M. Snowman, *Chlorine-Dependent Enhancement by Barbiturates of γ-aminobutyric Acid Receptor Binding*, 2 The Journal of Neuroscience 1812, 1812 (1982); Greenfield at 589; Charney at 414-16. The binding site for barbiturates is located in a different region of the $GABA_A$ receptor, distinct from the binding site for benzodiazepines. Ismar Newton Cestari *et al.*, *The Agonistic Action of Pentobarbital on $GABA_A$ β-subunit Homomeric Receptors*, 7 NeuroReport 943, 946 (1996); Charney at 414. While benzodiazepines enhance GABA inhibition by modulating the frequency of ion channel opening, barbiturates enhance GABA inhibition by increasing the time the ion channel remains open. Study & Barker at 7182-83; Charney at 406, 414.

Unlike benzodiazepines, which require the presence of GABA to produce a pharmacologic effect,

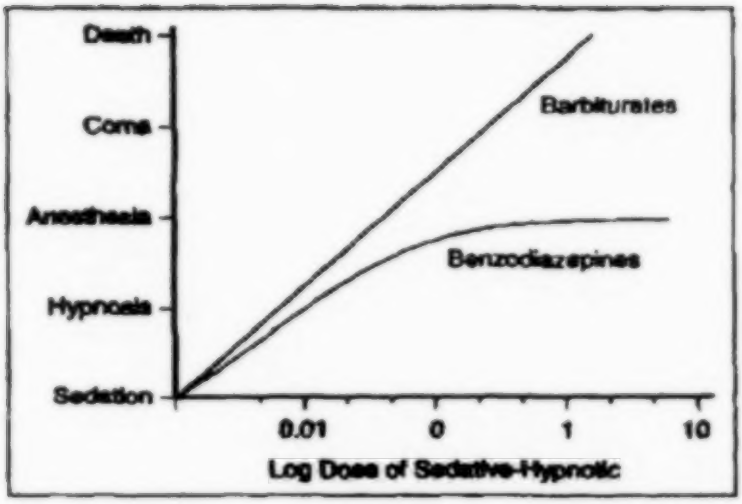
barbiturates confer neuronal inhibition even in the absence of GABA. David A. Mathers & Jeffrey L. Barker, *(–)-Pentobarbital Opens Ion Channels of Long Duration in Cultured Mouse Spinal Neurons*, 209 Science 507, 507-08 (1980); Meyer B. Jackson *et al.*, *Single Channel Currents Activated by γ-aminobutyric Acid, Muscimol, and (–)-Pentobarbital in Cultured Mouse Spinal Neurons*, 2 The Journal of Neuroscience 889, 890-93 (1982); Charney at 406. Therefore, the binding of barbiturates to the $GABA_A$ receptor opens the chloride ion channel in the absence of GABA and keeps the channel open longer than benzodiazepines. Robert L. Macdonald *et al.*, *Barbiturate Regulation of Kinetic Properties of the $GABA_A$ Receptor Channel of Mouse Spinal Neurones in Culture*, 417 Journal of Physiology 483, 491-96 (1989); Feyza Sancar & Cynthia Czajkowski, *Allosteric Modulators Induce Distinct Movements at the GABA-binding Site Interface of the GABA-A Receptor*, 60 Neuropharmacology 520, 527 (2011); Charney at 406, 414. In other words, even in the absence of GABA, barbiturates can increase the influx of chloride ions into the neuron to completely shut down the activity of the neuron.

D. Because Midazolam Requires Co-Binding of GABA and the Amount of GABA is Limited, Midazolam Cannot Overcome Sub-Anesthetic Levels To Provide General Anesthesia

As noted above, when a drug activates its receptor, it is called an agonist. A drug that activates its receptor to produce a maximal effect is called a full agonist; one that cannot produce the maximal

effect is called a partial agonist. Because benzodiazepines facilitate GABA actions, they are considered agonists. *E.g.*, Trevor J. Anthony & Walter L. Way, *Sedative-Hypnotic Drugs, in Basic & Clinical Pharmacology* 379, 379 (Bertram G. Katzung *et al.* eds., 12th ed. 2012); D'Hulst at 872. Yet because benzodiazepines require co-activation with GABA to produce a pharmacologic effect, and the amount of GABA is limited, they can produce only a partial agonist effect. George M. Brenner & Craig W. Stevens, *Sedative-Hypnotic and Anxiolytic Drugs, in Pharmacology* 186, 192 (Fig. 19-3) (4th ed. 2013) Barbiturates, on the other hand, act to inhibit neurons even in the absence of GABA and produce full agonist effects. *Id.* Thus, midazolam is only a partial agonist, and the depth of its inhibitory effect has limits.

This difference between full agonist and partial agonist explains why barbiturates like thiopental and pentobarbital can induce a "deep, comalike unconsciousness when given in the amounts used for lethal injection," *Warner*, 776 F.3d at 724 (citing *Baze*, 553 U.S. at 44), and why midazolam is incapable of "render[ing] an inmate unconscious prior to the injection of the second and third drugs," *id.* at 725. This difference, referred to as the "ceiling effect" of the benzodiazepine response, is illustrated in the figure below.



Brenner & Stevens at 192 (Fig. 19-3). As depicted above, greater doses of benzodiazepines will not produce greater pharmacological effects, while greater doses of barbiturates will produce greater pharmacological effects. *See id.* This is for two reasons. First, benzodiazepines require the presence of GABA to exert a pharmacological effect and barbiturates do not. *E.g.*, Charney at 405-06. Yet GABA is present in limited supply in the CNS, and the limited quantity of GABA restricts the pharmacological effect of benzodiazepines. *See, e.g.*, *id.* at 406. Second, benzodiazepines work differently. Specifically, benzodiazepines merely increase the frequency of ion channel opening when GABA is also present. Sigel & Steinmann at 40228; Study & Barker at 7183; Rogers at 69, 72-73, 77, 79; Charney at 406. Unlike barbiturates, benzodiazepines do not affect the duration of ion channel opening. *E.g.*, Charney at 406.

With reference to the increasing CNS effects on the vertical axis in the figure above, as the dose of benzodiazepine increases, the benzodiazepine curve

plateaus, reaching a "ceiling" before general anesthesia can be obtained. *See* Brenner & Stevens at 192 (Fig. 19-3). Therefore, the response to benzodiazepines cannot be further enhanced to unconsciousness and beyond by increasing the dose. *See id.* The fact that midazolam does not ever achieve general anesthesia is consistent with and explains the clinical uses of the drug. In fact, it is widely recognized in the scientific and medical community that midazolam alone cannot be used to maintain adequate anesthesia for surgery. *E.g.*, Reves at 318; Charney at 404 ("The clinical literature often refers to the 'anesthetic' effects and uses of certain benzodiazepines, but the drugs do not cause a true general anesthesia because awareness usually persists, and relaxation sufficient to allow surgery cannot be achieved."). By contrast, barbiturates do not exhibit this ceiling effect. *See* Brenner & Stevens at 192 (Fig. 19-3). Accordingly, increasing doses of barbiturates reliably produce anesthesia, coma, and death. *See id.*

In sum, midazolam's mechanism of action makes it unsuitable as the first drug in the State of Oklahoma's three-drug lethal injection protocol because it is incapable of inducing unconsciousness.

CONCLUSION

From a pharmacological perspective, midazolam is not interchangeable with barbiturates like thiopental or pentobarbital. Midazolam is incapable of rendering an inmate unconscious prior to the injection of the second and third drugs in the State of Oklahoma's lethal injection protocol. Therefore, midazolam is not appropriate for its

intended purpose as the first drug in the State of Oklahoma's three-drug lethal injection protocol.

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IN THE

Supreme Court of the United States

RICHARD E. GLOSSIP, ET AL.,
Petitioners,

v.

KEVIN J. GROSS, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

PETITION FOR REHEARING

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
A. The Court Should Grant Rehearing To Consider Whether The Death Penalty Is Unconstitutional Per Se.	1
B. Petitioners Exemplify Important Reasons Why The Death Penalty Is Unconstitutional.	2
C. The Petition Is Not For The Purpose Of Delay	8
CONCLUSION	9
CERTIFICATE OF COUNSEL	10

TABLE OF AUTHORITIES

Page(s)

CASES

Cole v. *State*, 164 P.3d 1089 (Okla. Crim. App. 2007) 6, 7
Davis v. *Ayala*, 135 S. Ct. 2187 (2015) (Kennedy, J., concurring)..... 7
Glossip v. *Gross*, 135 S. Ct. 2726 (2015) (Breyer, J., joined by Ginsburg, J., dissenting)..... *passim*
Glossip v. *State*, 157 P.3d 143 (Okla. Crim. App. 2007) 3
Glossip v. *State*, 29 P.3d 597 (Okla. Crim. App. 2001) 3
Grant v. *Oklahoma*, 540 U.S. 801 (2003) 5
Grant v. *State*, 95 P.3d 178 (Okla. Crim. App. 2004) (Chapel, J., dissenting) 5
Grant v. *Trammell*, 727 F.3d 1006 (10th Cir. 2013) (Briscoe, C.J., dissenting)..... 5
Obergefell v. *Hodges*, 135 S. Ct. 2584 (2015)..... 1
State ex rel. Okla. Bar Ass'n v. *McTeer*, 295 P.3d 1135 (Okla. 2013)..... 4
Youakim v. *Miller*, 425 U.S. 231 (1976) 1

OTHER AUTHORITIES

Amnesty Int'l, *Conditions for Death Row Prisoners in H-Unit, Oklahoma State Penitentiary* (1994)..... 6
Rachel Petersen, *OSP's H-Unit, Life on Death Row*, McAlester News-Capital (Dec. 6, 2011), http://www.mcalesternews.com/news/local_news/osp-s-h-unit-life-on-death-row/article_1fe445ba-3c8b-5843-a129-ef06d00367fc.html..... 6

TABLE OF AUTHORITIES—continued

Page(s)

Okla. Dep't of Corrections, Offender Search, Benjamin R. Cole Sr., ODOC #489814, http://tinyurl.com/ohxeron (last visited July 23, 2015) 7

Pursuant to Rule 44.1, petitioners respectfully petition this Court for rehearing of this case following the Court's decision of June 29, 2015. Petitioners submit that this case is an appropriate vehicle for ordering the full briefing on the constitutionality of the death penalty that Justice Breyer called for in his dissenting opinion.

A. The Court Should Grant Rehearing To Consider Whether The Death Penalty Is Unconstitutional Per Se.

This case did not originally challenge the constitutionality of the death penalty. In a dissenting opinion joined by Justice Ginsburg, however, Justice Breyer stated that he "would ask for full briefing on a more basic question: whether the death penalty violates the Constitution." *Glossip* v. *Gross*, 135 S. Ct. 2726, 2755 (2015) (Breyer, J., joined by Ginsburg, J., dissenting); see *id.* at 2777. As the Court very recently held, "[a]n individual can invoke a right to constitutional protection when he or she is harmed, even if the broader public disagrees and even if the legislature refuses to act." *Obergefell* v. *Hodges*, 135 S. Ct. 2584, 2605 (2015). In exceptional circumstances, which petitioners believe are present here, this Court will address issues not raised or passed on below. *Youakim* v. *Miller*, 425 U.S. 231, 234 (1976).

It would be appropriate for the Court to use this case to address the constitutionality of the death penalty because the outcome will turn not on facts specific to any single litigant, but on circumstances common to the administration of the death penalty. As Justice Breyer's opinion explains, the "circumstances and the evidence of the death penalty's application have changed radically" since this Court upheld the constitutionality of the death penalty nearly

forty years ago. *Glossip*, 135 S. Ct. at 2755 (Breyer, J., dissenting). The three petitioners here are well suited to present the full briefing for which Justices Breyer and Ginsburg called, on issues such as the unreliability, arbitrariness, delay, and decline in the application of capital punishment, which render such punishment unconstitutional under the Eighth and Fourteenth Amendments.

B. Petitioners Exemplify Important Reasons Why The Death Penalty Is Unconstitutional.

Although the constitutionality of the death penalty per se would not turn on the facts of any one litigant's case, petitioners' experiences with the capital sentencing system do illustrate many of the central concerns that underlie Justice Breyer's call for further briefing.

1. Richard Glossip – Reliability and Innocence: As the first of several reasons that the death penalty may violate the Eighth Amendment, Justice Breyer emphasized that the death penalty is not reliably reserved for those who commit the worst offenses, noting the "convincing evidence" that even "innocent people have been executed." *Glossip*, 135 S. Ct. at 2756 (Breyer, J., dissenting); see *id.* at 2756-59. Mr. Glossip is well-positioned to challenge the reliability of the death penalty as punishment for those who commit the most reprehensible crimes. He has always maintained his innocence.

Richard Glossip was 33 years old with no criminal record and a solid work history when he was charged with the murder of his employer, Barry Van Treese, the owner of the Oklahoma City motel where Mr. Glossip had worked as a live-in manager for over a year and a half. It is undisputed that a 19-year old

maintenance worker at the motel, Justin Sneed, used a baseball bat to kill Mr. Van Treese in one of the motel rooms. The State's theory was that while Mr. Glossip had no part in the actual killing of Mr. Van Treese, he asked Mr. Sneed to kill Mr. Van Treese and Sneed acquiesced. To avoid the death penalty, Mr. Sneed agreed to testify against Mr. Glossip. The only evidence that Mr. Glossip enlisted Sneed to kill Mr. Van Treese came from the admitted killer Sneed; as the Oklahoma Court of Criminal Appeals observed in vacating Mr. Glossip's conviction after his first trial: "The State concedes the only 'direct evidence' connecting Appellant to the murder was Sneed's trial testimony. No forensic evidence linked Appellant to murder and no compelling evidence corroborated Sneed's testimony that Appellant was the mastermind behind the murder." *Glossip* v. *State*, 29 P.3d 597, 599 (Okla. Crim. App. 2001).

In the words of the federal district court judge who reviewed his case in habeas, "[t]he State's case against [Mr. Glossip] hinged on the testimony of one witness, Justin Sneed, [Mr. Glossip's] accomplice, who received a life sentence in exchange for his testimony. Unlike many cases in which the death penalty has been imposed, the evidence of [Mr. Glossip's] guilt was not overwhelming." Order at 1-2, *Glossip* v. *Sirmons*, No. 5:08-cv-00326-HE (W.D. Okla. Sept. 29, 2010), ECF No. 66. Mr. Glossip's death sentence is based on only one aggravating factor—murder for remuneration—the evidence for which comes solely from the testimony of Sneed. *Glossip* v. *State*, 157 P.3d 143, 161 (Okla. Crim. App. 2007). Yet last fall, Mr. Sneed's daughter came forward and stated that her father has been afraid to recant his testimony about Mr. Glossip because he fears he would himself then be sentenced to death. She states: "I am sure

that Mr. Glossip did not do what my father originally said, that he did not hire my father to kill Mr. Van Treese . . ."[1]

2. John Grant – Arbitrariness and Mitigation: Justice Breyer's dissent also discusses the concern that the death penalty is imposed arbitrarily, noting that counsel's resources may factor into the arbitrariness of sentencing. *Glossip*, 135 S. Ct. at 2759-64 (Breyer, J., dissenting). Mr. Grant's counsel lacked the necessary resources, experience, and judgment to present the relevant mitigating evidence. It is defense counsel's duty to present mitigating evidence to support a case for a life sentence because "it remains the jury's task to make the individualized assessment of whether the defendant's mitigation evidence entitles him to mercy." *Id.* at 2763. In Mr. Grant's case, however, inexperienced counsel failed to present the jury with mitigation evidence that some judges who have since reviewed the case have opined would likely have affected the jury's decision.

Mr. Grant was represented by a lawyer who was new to the bar, who was self-medicating for untreated bipolar disorder, who married and then divorced her co-counsel in Mr. Grant's case in less than one year—all during her representation of Mr. Grant—and who later voluntarily resigned from the bar after being suspended from practice.[2] A majority of judges on the

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[1] Amended Petition for Writ of Habeas Corpus at 9, *Glossip* v. *Sirmons*, No. 5:08-cv-00326-HE (W.D. Okla. Jan. 8, 2015), ECF No. 84 (Letter from O'Ryan Justine Sneed dated Oct. 23, 2014)

[2] *See State ex rel. Okla. Bar Ass'n* v. *McTeer*, 295 P.3d 1135 (Okla. 2013) (mem.); *see also* Affidavit of Amy McTeer, ¶2, Nov. 18, 2014, attached as Ex. 29 to Clemency Petition for John Marion Grant submitted to the Oklahoma Pardon and Parole Board on Dec. 12, 2014.

Oklahoma Court of Criminal Appeals affirmed Mr. Grant's sentence, despite this Court having vacated and remanded his case for further consideration in light of *Wiggins* v. *Smith*, 539 U.S. 510 (2003). See *Grant* v. *Oklahoma*, 540 U.S. 801 (2003) (mem.). But the state-court opinion was not without dissent, which concluded, *inter alia*, that it believed that a jury, had it been presented with "the array of mitigating evidence that Grant's original jury never heard," may have been "sufficiently moved by the circumstances" to spare Mr. Grant's life. *Grant* v. *State*, 95 P.3d 178, 190 (Okla. Crim. App. 2004) (Chapel, J., dissenting).

Similarly, in reviewing Mr. Grant's habeas petition, the Chief Judge of the Tenth Circuit explained, "[h]ad Grant actually received the individualized consideration that the Constitution entitles him to, I believe that the testimony of Grant's family members would have placed not only the murder, but Grant's entire criminal history, into a different, and more sympathetic context for the jury." *Grant* v. *Trammell*, 727 F.3d 1006, 1042 (10th Cir. 2013) (Briscoe, C.J., dissenting). Because Mr. Grant was not provided adequate counsel to develop mitigating evidence, his sentence demonstrates the arbitrariness of capital sentencing—especially given the position of the dissenting judges who believe such information may have made a difference in his sentence.

3. Benjamin Cole – Delay and Dehumanization: Finally, the facts surrounding Mr. Cole's confinement illustrate Justice Breyer's concern regarding the "dehumanizing effect" of a lengthy term of solitary confinement. *Glossip*, 135 S. Ct. at 2765 (Breyer, J., dissenting). Mr. Cole has been confined on death row for over a decade. Like all condemned Oklahoma prisoners, he is housed in the H-Unit of the Oklahoma State

Penitentiary, which is underground housing with windowless cells and no access to open air or natural sunlight. See Rachel Petersen, *OSP's H-Unit, Life on Death Row*, McAlester News-Capital (Dec. 6, 2011 11:20 PM), http://www.mcalesternews.com/news/local_news/osp-s-h-unit-life-on-death-row/article_1fe445ba-3c8b-5843-a129-ef06d00367fc.html. The prisoners generally must spend 23 hours a day in their cell, which is 7'7" x 15'5"—no bigger than most bathrooms. *Id.*; see also Amnesty Int'l, *Conditions for Death Row Prisoners in H-Unit, Oklahoma State Penitentiary* 5 (1994). Five days per week, they have the option of spending an hour alone in a larger "cement room, approximately 20 feet by 20 feet, with a clouded skylight-type ceiling . . ." Rachel Petersen, *OSP's H-Unit, Life on Death Row*, McAlester News-Capital (Dec. 6, 2011 11:20 PM), http://www.mcalesternews.com/news/local_news/osp-s-h-unit-life-on-death-row/article_1fe445ba-3c8b-5843-a129-ef06d00367fc.html. They are never permitted to have physical contact with family or loved ones and communicate with visitors "through a set of steel bars and a window — and a telephone." *Id.* They are offered a 15-minute shower three times per week. Amnesty Int'l, *supra*, at 5.

Mr. Cole has schizophrenia, paranoid type. His illness has worsened without treatment over the years and has been exacerbated by the isolation on death row. He has not left his cell for years at a time. Test results show that he has an 11 millimeter lesion in the globus pallidus region of his brain.[3] The synergistic effects of his brain lesion and schizophrenia pro-

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[3] Defense counsel discovered Mr. Cole's brain abnormalities three weeks before trial, and requested a continuance, which the State opposed. *Cole* v. *State*, 164 P.3d 1089, 1093 (Okla. Crim. App. 2007). The trial court denied the continuance. *Id.*

vide an explanation for his behavior, including his lack of interest, his blank looks, and his monotone speech. See Affidavit of Linda Anne Hayman, M.D. at ¶¶ 5-6, *Cole* v. *Trammell*, No. 4:15-cv-00049-GKF-PJC (N.D. Okla. Jan. 30, 2015), ECF No. 2-43; see also Updated Report of Dr. Raphael Morris, *Cole* v. *Trammell*, No. 4:15-cv-00049-GKF-PJC (N.D. Okla. Jan. 30, 2015), ECF No. 2-42. Due to his illness, Mr. Cole has never been capable of meaningfully conferring with any of the attorneys who have attempted to represent him. At his trial, Mr. Cole "had withdrawn into extreme religiosity, made little if any effort to assist his attorneys or to prepare his defense while awaiting inspiration from God, and sat through the entire trial at counsel table literally not moving a muscle for hours on end while reading the Bible." *Cole*, 164 P.3d at 1093 (internal quotation marks omitted). He is currently represented by a next friend in this action, refuses to leave his cell, and fails to groom himself. See Okla. Dep't of Corrections, Offender Search, Benjamin R. Cole Sr., ODOC #489814, http://tinyurl.com/ohxeron (last visited July 23, 2015).

"[E]ven for prisoners sentenced to death, solitary confinement bears 'a further terror and peculiar mark of infamy.'" *Davis* v. *Ayala*, 135 S. Ct. 2187, 2209 (2015) (Kennedy, J., concurring) (citation omitted). Often, years in isolation can result in "a terrible price." *Id.* at 2210; see also *Glossip*, 135 S. Ct. at 2766-67 (Breyer, J., dissenting) (referencing the inhumane conditions on death row). The conditions under which Mr. Cole and the other petitioners live day-in and day-out also support rehearing and plenary consideration of the constitutionality of the death penalty.

C. The Petition Is Not For The Purpose Of Delay.

The Oklahoma Court of Criminal Appeals has now set execution dates for each of the petitioners, with the first such date being the execution of Richard Glossip on September 16, 2015, which is one of the dates that the State proposed. In setting these execution dates, the Oklahoma court stated that the pendency of a rehearing petition alone would not, as a matter of state statutory law, interfere with the State's ability to carry out the executions, and that the execution dates it has chosen are sufficiently far in the future to allow time so that petitioners "may file for rehearing with the United States Supreme Court" if they so choose.[4] The submission of this petition, therefore, is not for the purpose of delay, but rather to ask the Court to use this case to call for the briefing discussed in Justice Breyer's dissenting opinion. Should the Court grant this petition, however, it is petitioners' understanding that the proceedings in this Court would not yet be final, and the stay of execution that this Court previously granted would remain in place.

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[4] *See* Order Setting Execution Date, *Glossip* v. *State*, No. D-2005-310 (Okla. Crim. App. July 8, 2015) (setting execution date of September 16, 2015); Order Setting Execution Date, *Grant* v. *State*, No. D-2000-653 (Okla. Crim. App. July 8, 2015) (setting execution date of October 28, 2015). *But see* Order Setting Execution Date, *Cole* v. *State*, No. D-2004-1260 (Okla. Crim. App. July 8, 2015) (setting execution date of October 7, 2015, but finding that although Mr. Cole referenced the arguments made by Mr. Glossip and Mr. Grant regarding filing for rehearing, the court found the argument waived because he provided no independent argument in his papers). All orders are available on PACER, filed in *Glossip* v. *Gross*, No. 5:14-cv-00665-F (W.D. Okla. July 8, 2015), ECF No. 210-1.

CONCLUSION

For the foregoing reasons, petitioners pray that this Court grant rehearing of its decision.

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